86-471

No. —

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IN THE

Supreme Court of the United States

OCTOBER TERM, 1986

CARLOS T. COOPER, JR., D.P.M. and
E. JOSEPH DANIELS, D.P.M.,

Petitioners,

v.

FORSYTH COUNTY HOSPITAL AUTHORITY,
INC., *et al.*,

Respondents.

Petition for a Writ of Certiorari to the United States Court of Appeals for the Fourth Circuit

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September 21, 1986

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QUESTIONS PRESENTED

In response to the applications of two qualified podiatrists, the medical staff of Forsyth Memorial Hospital unanimously agreed to continue the blanket exclusion of podiatrists from the staff. Staff orthopedic surgeons, who compete against podiatrists for foot surgery and had vowed "to fight individually and collectively to keep podiatrists off the staff," actively opposed the applications. Acting as an appellate body, the Board of Trustees affirmed the staff's decision.

The podiatrists brought this antitrust action against the hospital, certain members of the staff and the Board of Trustees alleging a conspiracy to restrain trade. The district court granted summary judgment as to all defendants. The court of appeals affirmed, holding that there was no evidence to support the claimed conspiracy and that under this Court's ruling in *Monsanto Co. v. Spray-Rite Service Corp.*, 465 U.S. 752 (1984), defendants were entitled to judgment as a matter of law. The questions presented are:

1. Did the court below err in holding, in conflict with the Third Circuit's decision in *Weiss v. York Hospital,* 745 F.2d 786 (3d Cir. 1984), *cert. denied,* 105 S. Ct. 1777 (1985), that the medical staff of the Hospital was not a combination of individual doctors in competition with other practitioners, including petitioners, whose concerted action satisfied the contract, combination, or conspiracy requirement of Section 1 of the Sherman Act?

2. Did the court below err in granting summary judgment, thereby precluding all factual inquiry, where there was evidence that the medical staff: (a)

had control of the privilege-granting process at the Hospital; and (b) had obtained the Board of Trustee's approval through misinformation and coercion, in direct conflict with the Federal Trade Commission's enforcement policy in hospital access cases?

3. Did the court below misapply the dealer-termination conspiracy test of *Monsanto Co. v. Spray-Rite Service Corp.*, 465 U.S. 752 (1984), by ruling that a plaintiff alleging an exclusionary conspiracy among his direct competitors must present evidence tending to exclude the possibility of independent action?

LIST OF PARTIES

In addition to the respondent listed in the caption of the case, the other respondents in the case are as follows: Jack P. Barrier, Marian F. Brower, Harley P. Graves, J. Clifton Harper, Kap H. Halverson, Kenneth A. Johnson, Eugene Rossitch, G. Dee Smith, Ann Spencer, Raymond D. Thomas, Martha J. Young, William F. Folds, M.D., David Nelson, M.D., William F. Sayers, M.D., and Louis Shaffner, M.D., individually and as trustees of Forsyth County Hospital Authority; George Podgorny, M.D.; Robert Means, M.D.; Jeff B. Helms, M.D.; Frank E. Pollock, M.D.; Kenneth G. Tomberlin, M.D.; John T. Hayes, M.D.; Richard P. Rose, M.D.; Robert G. Underdal, M.D.; Isabel Bittinger, M.D.; Jerome E. Jennings, M.D.; The Medical Society of the State of North Carolina; the North Carolina Orthopaedic Association, Inc.; and Carolyn Green, individually and as a trustee of Forsyth County Hospital Authority.

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CARLOS T. COOPER, JR., D.P.M. AND
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Petitioners,

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FORSYTH COUNTY HOSPITAL AUTHORITY,
INC., *et al.*,
Respondents.

PETITION FOR A WRIT OF CERTIORARI TO THE UNITED STATES COURT OF APPEALS FOR THE FOURTH CIRCUIT

Carlos T. Cooper, Jr., D.P.M. and E. Joseph Daniels, D.P.M. petition for a writ of certiorari to review the judgment and opinion of the United States Court of Appeals for the Fourth Circuit entered on April 24, 1986.

OPINIONS BELOW

The opinion of the court of appeals, set forth in App. A, is reported at 789 F.2d 278 (4th Cir. 1986). The opinion of the district court, set forth in App. B, is reported at 604 F. Supp. 685 (M.D.N.C. 1985).

JURISDICTION

The judgment of the court of appeals was entered on April 24, 1986. On July 22, 1986, Chief Justice Burger extended the time to petition for certiorari to and including September 21, 1986. The jurisdiction of this Court is invoked under 28 U.S.C. § 1254(1).

STATUTES INVOLVED

Section 1 of the Sherman Act provides in pertinent part that "[e]very contract, combination in the form of trust or otherwise, or conspiracy, in restraint of trade or commerce among the several States, or with foreign nations, is hereby declared to be illegal."

STATEMENT OF THE CASE

Petitioners are podiatrists practicing in Winston-Salem, North Carolina. In 1980 and again in 1981, their applications (for privileges to co-admit patients[1] at Forsyth Memorial Hospital ("Forsyth Memorial") were denied. The denial was based on the unanimous recommendation of the medical staff's Executive Committee, later endorsed by the hospital's Board of Trustees, that all podiatrists should be excluded from the hospital, irrespective of their individual character, experience, and professional competence. This case involves petitioners' antitrust challenge to this blanket exclusion.

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[1] In accordance with standards of the Joint Commission on Accreditation of Hospitals, petitioners had applied for the right to admit patients "with the concurrence of a physician member of the medical staff." App. F at 59a.

1. The Factual Setting

(a) The professional standing of petitioners and of podiatry in general

Petitioners' good character and professional competence are not disputed. They are graduates of Wake Forest University, received doctorates from the Ohio College of Podiatric Medicine, and have successfully practiced foot surgery for more than eighteen years. Each has been President of the North Carolina Podiatric Medical Society; each has been a member of North Carolina's Board of Podiatry Examiners; and each is a fellow of the American College of Foot Surgeons and is board-eligible for the American Board of Podiatric Surgery. Their individual qualifications were deemed to be irrelevant because, as one of the orthopedist-respondents, Dr. Underdal, explained at a September, 1980 meeting of the North Carolina Orthopaedic Association, "no credentials have been reviewed since [the medical staff is] currently reviewing the art of podiatry. Until this has been found acceptable, individual credentials will not be reviewed." App. S at 125a.

In fact, the "art of podiatry" had already been studied in depth by the Joint Commission on Accreditation of Hospitals (JCAH), the American Medical Association (AMA), the United States Department of Health and Human Services, and other reputable medical organizations. Without exception, they had concluded that podiatrists, as a professional group, were fully qualified for clinical privileges and should be granted such privileges based on their individual "documented training, experience, and current compe-

tence."[2] On February 1, 1980, the North Carolina Hospital Association (NCHA) recommended that its members adopt new bylaws allowing clinical privileges for podiatrists based on their "training, experience and current demonstrated competence and judgment." App. G at 60a.

The acceptance of podiatry by JCAH, AMA and all other medical organizations reflects the high quality of podiatric education. "The training regimen tends to be equivalent to that of physicians, except that podiatrists specialize in disorders relating to feet."[3] As an August 1980 Report of the North Carolina Governmental Evaluation Commission concluded, "[w]ith the improved educational and testing requirements for licensure today, the objections to extending hospital privileges to podiatrists are no longer persuasive." App. X at 156a. Accordingly, the Report condemned "the blanket exclusion of podiatrists from consideration for hospital privileges . . . ." *Id.* at 157a. Despite the unanimous opposition to the exclusion of podiatrists by the AMA, JCAH, NCHA, the Department of Health and Human Services, and the North Carolina Governmental Evaluation Commission, respondents have maintained such a categorical exclusion at Forsyth Memorial.

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[2] Statement on Hospital Privileges for Podiatrists by the Joint Commission on Accreditation of Hospitals, App. F at 59a. For the AMA's similar statement, *see* App. E at 58a. The Department of Health and Human Services has adopted the position that a hospital which "excludes podiatrists from consideration would not be in compliance with Medicare requirements." App. H at 63a.

[3] Dolan & Ralston, *Hospital Admitting Privileges and the Sherman Act*, 18 Hous. L. Rev. 707, 728 (1981) ("Houston Article").

(b) The competitive effect of the blanket exclusion of podiatrists

Petitioners' economic expert identified the relevant product market as the "rendering of in-patient foot surgery services which both orthopedic surgeons and podiatrists are authorized by state law to perform." App. I at 65a. He further found that competition in that market "is limited essentially to the competition between podiatrists and orthopedic surgeons." *Id.* at 66a. Because approximately 70 percent of the patients who had in-patient foot surgery at Forsyth Memorial "reside in Forsyth County," he found that county to be "the relevant geographic market." *Id.* at 66a-67a. Forsyth Memorial is the largest hospital in the county, with 49 percent of all admissions,[4] and it is generally perceived as the primary provider "of medical care for the Forsyth County community." App. I at 67a. Furthermore, it has "a de facto monopoly over . . . admitting privileges . . . in the Forsyth County community." *Id.* at 68a.[5] Thus, it is the only hospital to which independent practitioners, such as petitioners, could realistically turn. Lacking admitting privileges at Forsyth Memorial, petitioners were forced, over a five year period, to refer approximately 388 of their patients to physicians, usually orthopedists, who had the requisite clinical privileges. Patient Charts for

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[4] Excerpt, American Hospital Association Journal (Exhibit 18, Plaintiffs' Motion for Summary Judgment).

[5] While there are two other hospitals in the county, one is a teaching hospital which cannot grant admitting privileges to "practitioners who are not faculty members." The other is a proprietary hospital which grants privileges only to "practitioners who possess proprietary interests in that hospital." App. I at 68a.

Doctors Cooper and Daniels (App. Ex. 25 to Plaintiffs' Brief in Support of Motion for Partial Summary Judgment).

(c) The staff appointment process at Forsyth Memorial

The respondent, Forsyth County Hospital Authority, has made the medical staff "responsible for the quality of medical care in the Hospital." App. D at 35a. This includes determining who shall be granted clinical privileges subject only to limited appellate review by the Board. Accordingly, every application for such privileges is sent to the staff's Credentials Committee for evaluation. *Id.* at 39a. The Credentials Committee's recommendation is then forwarded to the staff's Executive Committee. *Id.* at 40a. If the Executive Committee's determination is adverse, and the practitioner elects to appeal, he is entitled to a hearing before "an ad hoc hearing committee" of the staff. *Id.* at 46a. If that fails, the applicant may request "an *appellate review* by the [Board]" which "shall act as *an appellate body*." *Id.* at 48a-51a (emphasis added). The standard on appeal is whether the adverse decision was "arbitrary or capricious" (*id.* at 50a), and matters not raised at the staff hearing level may be raised "at the appellate review only under unusual circumstances." *Id.* Should the Board's decision be contrary to the staff's recommendation, the Board "shall submit the matter to a Joint Conference Committee for further review and recommendation and shall consider such recommendation before making its decision final." *Id.* at 43a.

(d) The consideration of petitioners' applications for surgical privileges

Petitioners first applied for clinical privileges on April 21, 1980, shortly after the North Carolina Hos-

pital Association had recommended that "all hospitals" amend their bylaws to permit podiatrists to be considered on the basis of their individual qualifications. App. G at 60a-61a. Forsyth Memorial established a Bylaws Committee to determine whether the Bylaws' blanket exclusion of podiatrists should be changed. Hearings were held during the summer of 1980 at which orthopedic surgeons expressed strong opposition to any change in the status quo. App. J at 69a-77a. The Bylaws Committee's Report, issued August 5, 1980, unanimously agreed with the orthopedists that the exclusion of podiatrists should "remain unchanged." App. K at 80a. The "primary basis" for this decision was that Forsyth Memorial "has several orthopedic surgeons on its staff, all of the functions performed by a podiatrist may be performed by an orthopedic surgeon," and podiatrists, according to the Committee, did not receive medical education equivalent to orthopedic surgeons. *Id.* at 79a. The Bylaws Committee's Report was unanimously adopted by the staff's Executive Committee and by the staff itself. App. W at 151a. On September 9, 1980, the Report was submitted to the Hospital's Board of Trustees which unanimously adopted it, without change, on October 14, 1980. App. L at 82a-98a.

On September 25, 1981, petitioners reapplied for co-admitting privileges. They were encouraged to do so by enactment of a new state statute that required hospitals to base the grant or denial of privileges on the individual applicant's education, training, competence and experience. As an apparent concession to this statute, the Hospital purported to consider petitioners' applications under the normal credential-

ing process. On January 5, 1982, the staff's Credentials Committee and Executive Committee unanimously rejected petitioners' application. App. M at 99a-104a; App. N at 105a-108a. The Board affirmed, unanimously rejecting the applications on February 9, 1982. App. O at 109a-112a; App. P at 113a-119a.

Although petitioners' 1981 applications were ostensibly considered on an individual basis, they were denied solely because petitioners were not trained as orthopedic surgeons. No attempt was made to deal with petitioners' *individual* qualifications (the reports on each were verbatim the same (App. M at 99a-104a)); and the Credentials Committee had only positive information concerning petitioners' character, high ethical standing, and professional competence and judgment. Deposition of William F. Folds, M.D. at 16. As counsel for the hospital candidly described the process to the Board at the time, when petitioners "are considered on their individual merits . . . they are always found, because they are podiatrists and not orthopedic surgeons, to not have the training and experience which an orthopedic surgeon has." App. O at 111a.

(e) The role of the orthopedic surgeons and the North Carolina Orthopaedic Association

The blanket exclusion of podiatrists from Forsyth Memorial was only one episode in a long-standing war by North Carolina orthopedists against podiatry. In October 1975, the North Carolina Orthopaedic Association (NCOA) went on record as being "totally opposed to the hospital practice of podiatry." App. R at 122a. This position was reaffirmed a year later (App. S at 124a), and, in November 1985, the Federal

Trade Commission filed a complaint attacking NCOA's unreasonable restraint on "the practice of podiatry." In the matter of North Carolina Orthopaedic Association, File No. 841-0038, App. U at 130a-133a. The complaint alleged that NCOA had, among other things, "passed two resolutions opposing the hospital practice of podiatry [and] enjoined [its members] to review or change hospital bylaws accordingly . . . ." *Id.* at 132a. As a result, the complaint alleged, patient "choice has been hindered" and the "ability of podiatrists to compete with medical doctors has been restricted." *Id.* at 133a. In November 1985, NCOA signed a consent order. *Id.* at 134a-136a.

At NCOA meetings held on September 11 and 12, 1980, while the Board was still considering the Bylaws Committee's Report, the Chairman of the Department of Orthopedic Surgery at Forsyth Memorial, Dr. Underdal, reported on developments at the Hospital. He assured NCOA "that *the staff . . . will fight individually and collectively to keep podiatrists off the staff.*"[6] App. S at 125a (emphasis added). Later, he

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[6] The record is clear that they lived up to this commitment. While no less than five orthopedists testified at the hospital hearings, not one mentioned the JCAH, AMA, or NCHA endorsements of podiatry, and their testimony was uniformly antagonistic and misleading. For example, although he knew little about podiatry, Dr. Underdal testified that he was "opposed to everything about podiatry." App. J at 75a. Dr. Rose objected to podiatrists because "they . . . were not properly trained enough to be competent in caring for medical illnesses that may" occur before or after surgery. Deposition of William F. Folds, M.D., at 20. In fact, as Dr. Rose must have known, podiatrists would have been required to co-admit with a physician who would be responsible for any medical illness that arose. *See* App. F at 59a. Furthermore, the orthopedists' vote not to supervise

"expanded on the activity in Winston-Salem," reporting that "*individual credentials will not be reviewed*" until the podiatry profession "has been found acceptable" and that "[*t*]*he orthopaedic surgeons have voted that none will supervise podiatrists in* [*the*] *hospital.*" *Id.* (emphasis added).

2. The Proceedings Below

Petitioners commenced this antitrust action on February 1, 1983, and amended their complaint on August 19, 1983. The amended complaint named as defendants Forsyth County Hospital Authority, its individual trustees, seven orthopedic surgeons on the staff at Forsyth Memorial, several other medical staff members who had most actively participated in the exclusionary conduct alleged in the amended complaint, and NCOA and the Medical Society of North Carolina. App. C at 19a-21a.

The amended complaint charges that the "actions of the [respondents] jointly and severally" had "denied podiatrists as a group . . . the right to practice their profession in the only public acute hospital available to them in the relevant market." *Id.* at 29a. It expressly challenges actions of the Executive Committee in twice voting to continue the "exclusion of podiatrists as a class from clinical privileges at Forsyth Memorial Hospital." *Id.* at 26a-28a. It alleges

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podiatrists placed a substantial roadblock in the path of the podiatrists since the Bylaws provide that "[p]eriodic redetermination of clinical privileges and the increase or curtailment of same shall be based upon the direct observation of care provided . . . ." Bylaws, VI.1(c). As a physician-member pointed out to the Board, "The logical active staff member to perform this task would be an orthopaedist." App. L at 91a. Yet, the orthopedists had agreed not to perform this necessary function.

that ten physician staff members, including all members of the staff Bylaws Committee, four members of the staff Credentials Committee, and at least two staff Executive Committee members, including its president, Dr. Folds, conspired to deny petitioners coadmitting privileges. *Id.* at 29a-30a. The amended complaint sought treble damages and injunctive relief. *Id.* at 33a-34a.

Plaintiffs moved for partial summary judgment on March 12, 1984, and defendants filed for summary judgment on June 20, 1984. On March 14, 1985, the district court denied plaintiffs' motion and granted defendants'. App. B at 17a. In doing so, the district court assumed there was proof of conspiracy, but found that respondents "had a duty to insure that the hospital provide quality patient care and that the actions by the Board and the Bylaws Committee were in response to this duty." App. B at 14a.

The court of appeals affirmed. It recognized that "podiatrists and orthopedists arguably would compete to perform certain surgical procedures," (App. A at 3a) "that orthopedists appeared before the bylaws committee and opposed the granting of surgical privileges to podiatrists, and that the bylaws committee recommended to the board of trustees that podiatrists be denied surgical privileges." App. A at 7a. It held, however, that this amounted to nothing more than "the mere opportunity to conspire . . ." and that this was not "evidence which 'tends to exclude the possibility of independent action.'" *Id.*, quoting from *Monsanto Co. v. Spray-Rite Service Corp.*, 465 U.S. 752, 768 (1984). The court also observed that respondents had "represented" that they had excluded podiatrists "on quality of patient care grounds

. . . ." App. A at 8a. Although there were genuine issues of fact as to this contention,[7] the court found it to be a "legitimate reason" that weighed against inferring a conspiracy. *Id.* at 7a.

REASONS FOR GRANTING THE WRIT

Supreme Court review of this hospital access antitrust case is required for the following reasons: *First.* The question of access to hospital facilities for qualified nonphysician health care providers is important and recurring. The antitrust laws, correctly applied in hospital privileges cases, can insure the benefits of competition and free choice to patients, as well as podiatrists, osteopaths, clinical psychologists, and other non-M.D. providers. *Second.* There is a direct conflict between the Fourth Circuit's decision in this case and the Third Circuit's decision in *Weiss v. York Hospital*, 745 F.2d 786, 814 (3d Cir. 1984), *cert. denied*, 105 S. Ct. 1777 (1985). *Third.* The decision below also conflicts with the Federal Trade Commission's well-defined enforcement policy. *Fourth.* This case provides an opportunity for this Court to make clear that its recent decisions in *Monsanto Co. v. Spray-Rite Service Corp.*, 465 U.S. 752 (1984) and *Matsushita Electric Industrial Co., Ltd. v. Zenith Radio Corp.*, 106 S. Ct. 1348 (1986) involved special situations and have not overruled or modified *Poller v. Columbia Broadcasting System, Inc.*, 368 U.S. 464, 473 (1962).

Because the decision below presents a serious threat to governmental, as well as private, antitrust enforcement in hospital access cases, we respectfully suggest

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[7] *See* discussion, *supra* at 3-4 and *infra* at 28.

that the Court request the views of the Federal Trade Commission and Department of Justice as to both its merits and significance.

I. Access To Hospital Facilities By Nonphysician Health Care Providers Presents An Important And Recurring Issue Of National Significance

The modern hospital has a critical role in our health care system.[8] Certain types of diagnoses and treatment can only be done in the hospital and others can best be performed there. Thus, the patient and his physician, or nonphysician health care provider, often need access to "the essential facilities of a twentieth century hospital." *Shaw v. Hospital Authority*, 507 F.2d 625, 629 (5th Cir. 1975) (Brown, C. J. concurring).

The key to access is hospital admitting privileges. Only patients sponsored by a practitioner who has such privileges will be admitted. Houston Article at 709-10.

> Therefore, privileges decisions are more than a bureaucratic formality: they literally control provider access to particular hospitals for particular procedures and thereby affect both providers and consumers of health care.[9]

Failure to secure hospital admitting privileges means that patients requiring hospitalization must be re-

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[8] *See* Note, *Health Professionals' Access to Hospitals: A Retrospective and Prospective Analysis*, 34 Vand. L. Rev. 1161-1166 (1981) ("Vanderbilt Note").

[9] I W. Lazarus, F. Levine, L. Lewin, Report for the FTC: Competition Among Health Practitioners at IV-1 (Feb. 1981) ("FTC Report").

ferred to a provider who has privileges. This not only reduces the referring provider's income, but it also significantly lowers his professional status. Houston Article at 713-14. "For the provider whose economic viability depends on hospital access, the grant of privileges by a facility in his or her locality is critical." FTC Report at IV-1.

The patient-consumer's interest "in admitting privileges turns on two general factors, cost and freedom of choice." Houston Article at 719; *see also* FTC Report at IV-1. Where the patient would have chosen a nonphysician provider to treat his health problem, such as a podiatrist to perform foot surgery, the lack of admitting privileges will preclude that choice altogether, and is likely to increase the cost of the procedure by compelling referral to an M.D. FTC Report at IV-1.

Moreover, to the extent hospitals deny privileges to certain classes of health care providers, they restrict supply and thus increase overall health care costs. Houston Article at 720. These artificial restrictions on supply may have contributed to the escalating cost of health care which reached over $245 billion in 1980 (9.5% of the GNP) and has become an issue of major concern. FTC Report at i.

The emergence of several new health care providers has compounded the problem of hospital access.

> In the recent years, various non-physician professionals have emerged and grown in number. For many of them, hospital practice is both permitted by state scope of practice acts and, some believe, key to their optimal utilization in the health care market. How-

> ever, the medical establishment has been slow to accommodate the new professionals in the hospital privileges context.

Id. at IV-39. In addition to osteopaths, podiatrists, and chiropractors, the nonphysician health care providers seeking hospital access now include clinical psychologists, nurse practitioners, and nurse midwives. Vanderbilt Note at 1185-98; FTC Report at IV-40 - IV-47; Houston Article at 728-33; *cf. Blue Shield of Virginia v. McCready*, 457 U.S. 465 (1982).

Typically, it is the M.D. medical staff of the hospital that effectively controls hospital privileges decisions. *See* FTC Report at IV-18; Kissam, Weber, Bigus, Holzgraefe, *Antitrust and Hospital Privileges: Testing the Conventional Wisdom*, 70 Calif. L. Rev. 595, 607-08 (1982) ("California Article"). Moreover, the M.D. staff and local medical societies have often been hostile to allowing access to any new group of health care providers. FTC Report at IV-43. Orthopedic surgeons, in particular, have frequently employed both formal and informal techniques to thwart hospital access by podiatrists. *Id.*

In the present case, there is clear evidence that the local M.D. organizations had declared war on podiatrists. The President of the North Carolina Medical Society warned that "[m]edicine is facing an immense crisis" caused by the "'inroads' into the practice of medicine" being made by "[n]urses, podiatrists, psychologists, pharmacists, physicians' assistants . . . physical therapists, optometrists, chiropractors, and x-ray technicians." App. T at 127a. The North Carolina Orthopaedic Association announced that it was "totally opposed to" and "strongly disapproves of" the hospital practice of podiatry. App. R at 122a-123a.

The orthopedic surgeons at Forsyth Memorial were committed to "fight individually and collectively to keep podiatrists off the staff" (App. S at 125a) and voted that "none will supervise podiatrists in that hospital." *Id.*

These serious threats to consumer welfare are not limited to Forsyth Memorial or to North Carolina.

> [T]here is a good reason to believe that most hospital by-laws concerning staff and clinical privileges will, at a minimum, conform to the accreditation standards of the Joint Commission on Accreditation of Hospitals (JCAH). The basic JCAH standard on privileges provides that the hospital's governing board "shall delegate to the medical staff the authority to evaluate the professional competence of staff members and applicants" and, further, that the board "shall hold the medical staff responsible for making recommendations" to the board on privilege issues.

California Article at 606 (footnote omitted). Thus, the key Bylaw provisions at issue here, which give the physician staff effective control of the privilege-granting process, probably appear in the Bylaws of most hospitals in the United States.

Moreover, even if the Bylaws do not formally delegate control of hospital access to the staff,

> [f]rom a political point of view, medical staffs generally seem to control privilege decisions, or at least to share the ultimate authority over these issues with hospital governing boards. Historically, governing boards rarely have departed from medical staff recommen-

> dations on privilege issues. This may be explained by the deference historically accorded to the presumed technical expertise of physicians, as well as deference accorded to them because of their cultural authority and political power within local communities.

California Article at 607-08 (footnote omitted).

Because of the institutional control exerted by M.D.'s and the high stakes involved, disputes over the denial of hospital access have risen dramatically in recent years. As a result, the federal courts have increasingly been called upon to resolve hospital access controversies. Since 1980, the courts have resolved 115 hospital access cases compared to only 37 cases in the prior six year period.[10]

The growing interest of the public and the health care community, together with the expanding involvement of the federal courts, have made hospital access a genuinely important and recurring issue of national significance.

II. The Fourth Circuit's Decision In This Case Summarily Affirming Denial Of Hospital Access Conflicts With The Third Circuit's Decision In Weiss v. York Hospital

In a well-reasoned and careful opinion, the Third Circuit in *Weiss* held that:

> [A]s a matter of law, the medical staff is a combination of individual doctors and there-

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[10] A September 9, 1986 LEXIS search of the "newer" federal court decisions revealed 115 reported decisions since 1980, and 37 from 1974 to 1979 involving challenges to the denial, revocation or restriction of hospital privileges.

> fore . . . any action taken by the medical staff satisfies the "contract, combination, or conspiracy" requirement of Section 1.

Weiss, 745 F.2d at 814. Under *Weiss*, this does not end the antitrust inquiry; because denial of hospital privileges may be "justified on 'public service or ethical norm' grounds . . . the rule of reason may still control, as a 'built-in' exception." *Id.* at 820. Thus, had the Fourth Circuit followed *Weiss*, the contract, combination or conspiracy element would have been satisfied by the actions of the medical staff, itself,[11] and jury consideration of the alleged "quality of patient care grounds" would then be required. App. A at 8a.

The court of appeals recognized that *Weiss* had held "that the medical staff of the hospital is a combination of individual doctors . . ." for Section 1 purposes. *Id.* at 8a n.12. The court "question[ed] that position," but claimed it was unnecessary "to resolve that issue" because petitioners "did not allege a conspiracy among the members of the medical-dental staff."[12] *Id.*

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[11] Under *Weiss*, it would have been meaningless that there was not clear proof that the orthopedic surgeons, the North Carolina Orthopaedic Association or the Hospital's Board had conspired with each other or with the medical staff. "[B]ecause the medical staff itself is a combination as a matter of law . . . the absence of evidence of any other co-conspirator(s) is irrelevant." 745 F.2d at 814.

[12] The Fourth Circuit's attempt to brush aside *Weiss* on this ground is incomprehensible. The amended complaint clearly challenges the exclusionary conduct of the medical staff, acting through its Executive Committee, in twice voting to continue the "exclusion of podiatrists as a class from clinical privileges

In fact, there is a direct conflict between this case and *Weiss*. The Third Circuit's decision in *Weiss* was based on the *de facto* control exercised by the medical staff in the credentialing process at York Hospital. Relying on studies that had examined the relationship between "the Medical Staff Executive Committee and the Board of Directors" (*Weiss*, 745 F.2d at 796 n.14), the court found that "[f]ormalities are misleading .... [T]he significant entity in the application process is the medical staff." *Id.*, quoting from Houston Article at 711-12. The court also found that "the hospital board functions as a reviewing court that recognizes substantial discretion in the staff and upholds the staff's decision if it is supported by any 'rational basis' or 'substantial evidence.'" *Id.*, quoting from California Article, at 641.

Examination of the credentialing process confirmed that these principles correctly described the realities at York Hospital (*Weiss*, 745 F.2d at 796-799). Accordingly, the court concluded that the medical staff was a group of physicians who had "organized to regulate the provision of medical care at York hospital" and whose actions, therefore, were "subject to scrutiny under Section 1 of the Sherman Act." *Weiss*, 745 F.2d at 816.

There can be no doubt that the Forsyth Memorial medical staff exercises at least as much control over

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at Forsyth Memorial ...." (Amended Complaint, ¶¶ 25, 31, App. C at 26a-28a) and ten staff members, including two Executive Committee members, were named as defendants. It is not necessary to sue the entire medical staff, as was done in *Weiss*. Indeed, "it is permissible to sue but one of several alleged co-conspirators." Hennessey v. National Collegiate Athletic Association, 564 F.2d 1136 (5th Cir. 1977).

hospital access as does the staff at York Hospital. Although at both hospitals, the Boards ostensibly make the ultimate decision (*compare Weiss*, 745 F.2d at 799 *with* App. D at 42a-43a), the staff's "recommendations" are dispositive in practice. Thus, at both, the staff's credentials and executive committees review applications and make recommendations. *Compare Weiss*, 745 F.2d at 796 *with* App. D at 39a-43a. At both hospitals, when the executive committee recommends denial of privileges, the applicant can appeal either to a Judicial Review Committee, under the York Hospital procedure (*Weiss*, 745 F.2d at 796), or directly to the Board at Forsyth Memorial. App. D at 44a.

In either case, the standard of review applied makes the staff's initial determination effectively final. At York, the test applied by the Judicial Review Committee is whether it was "in error, unreasonable, arbitrary or capricious." *Weiss*, 745 F.2d at 796. At Forsyth Memorial, the Board functions "as an appellate body" and applies an "arbitrary or capricious" standard. App. D at 50a. If anything, the medical staff's control is greater at Forsyth Memorial since its bylaws provide that the Board of Trustees may never reject the staff's recommendation without submitting the matter to a "Joint Conference Committee with the staff for further review and recommendation." *Id.* at 42a-43a.

Under the credentialing procedures at both hospitals, staff physicians who compete with each other and with the applicants, have been delegated the right to make the crucial first recommendation. Hence, in both *Weiss* and this case, the "significant entity in the application process is the medical staff" (*Weiss*,

745 F.2d at 796 n.14); and in both, under the antitrust principles carefully considered and applied in *Weiss*, the contract, combination, or conspiracy requirement is satisfied as a matter of law. For these reasons, this Court should resolve the conflict and rectify the error of the Fourth Circuit.

III. The Fourth Circuit's Decision Conflicts With Federal Trade Commission Enforcement Policy In Hospital Access Cases

Supreme Court review is also required because the Fourth Circuit's decision conflicts with the Federal Trade Commission's position that the exclusionary action of a medical staff can be sufficient, in itself, to satisfy the contract, combination and conspiracy requirement of Section 1.[13] This concept, which is crit-

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[13] The Commission has taken or endorsed that position in two recent cases. In its complaint in *Health Care Management Corporation*, FTC File No. 841-0116 (1985), the Commission alleged that the medical staff had acted "as a combination of its members"; that the staff had "pressure[d] individual physicians not to co-admit patients with any podiatrist"; that the medical staff had imposed various "restrictions unreasonably limiting the practice of podiatry within the Hospital"; and that the Hospital, itself, had "approved or enforced these restrictions and thereby joined in the *aforesaid combination and conspiracy*." Complaint, ¶¶ 8, 9, App. V at 139a-140a (emphasis added). Similarly, in a 1985 *amicus curiae* brief, the Commission emphasized the "danger that, in some cases, physicians will attempt to use their influence in the privilege granting process to protect themselves from unwanted competition, with resulting harm to consumers"; and it cited *Weiss* with approval as a case where "allopathic physicians were found to have excluded osteopathic physicians from a hospital without reasonable justification." Brief for the Federal Trade Commission as *Amicus Curiae* at 13-14, Lombardo v. Our Lady of Mercy Hospital, No. 85-2474 (7th Cir.) (filed Nov. 7, 1985).

ical to the Commission's enforcement program in hospital privileges cases, was rejected by the Fourth Circuit's decision in this case.

The Commission's enforcement policy is defined in two statements: (1) Federal Trade Commission, *Enforcement Policy With Respect to Physician Agreements to Control Medical Prepayment Plans (1981)* ("Physician Control Statement"); and (2) Winslow, *Antitrust and Alternative Health Care Systems*, presented to the Antitrust and Health Care Sections, Minnesota State Bar Association May 25, 1983 ("Winslow Paper"). The Physician Control Statement sets forth the basic antitrust analysis that underlies both *Weiss* and the Commission's enforcement approach:

> [W]hen a business, trade association, or any other similar organization is controlled by a group of competitors, its actions are scrutinized under the antitrust laws as the concerted activity of competitors, without having to trace the activity directly back to a specific agreement or directive of the controlling group.

Physician Control Statement at 6-7. Under this analysis, a "finding that a [medical prepayment] plan is physician-controlled will subject the plan's actions and policies to the antitrust standards applicable to concerted activity by competitors." *Id.* at 9. Such physician control "may be either formal or *de facto*" (*id.*); and, as "with factual issues in other areas of antitrust enforcement, substance will govern over form in determining whether control exists." *Id.* at 10. Plainly, this contemplates a reasoned factual inquiry on the

physician control issue, not, as here, the summary rejection of petitioners' antitrust claim for failing to provide ironclad proof of a conspiracy *between* the medical staff and other entities.

Applying this analysis to medical staff decisions relating to hospital privileges, the Commission has indicated that when the staff "has control of the privilege-granting process . . . —either through a formal delegation or informally," then the requisite contract, combination, or conspiracy exists on two grounds: *First*, the "delegation of decision-making authority amounts to a combination between the hospital and the medical staff," (Winslow Paper at 13); and, *second*, "the hospital's 'actions or policies resulting from the delegation, as well as physician group activities in exercise of its delegated authority, will be analyzed as concerted action and will therefore be unlawful if they unreasonably restrain trade.'"[14] *Id.* at 13-14, quoting from Physician Control Statement at 12.

The FTC has also made clear that "[i]f there is no formal delegation of authority to the physician group, deciding whether the medical staff controls the granting of privileges will be a factual question much like the 'control' issue discussed in the . . . Physician Con-

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[14] Under both *Weiss* and the Commission's antitrust methodology, the existence of concerted activity does not end the inquiry. As the court held in *Weiss*, the denial of privileges could be justified on "'public service or ethical norm' grounds" so that the "rule of reason analysis may still control . . . ." 745 F.2d at 820. Mr. Winslow likewise makes clear that Commission enforcement policy would require a showing that the denial of privileges had "significant anticompetitive effects not outweighed by any procompetitive effects." Winslow Paper at 15.

trol Statement." *Id.* at 13 n.11. The Fourth Circuit, however, by rejecting *Weiss's* conclusion that the staff can be a combination for Section 1 purposes and summarily dismissing the complaint, has foreclosed all factual inquiry on the issue of physician control, which is an essential element of the Commission's enforcement methodology.[15]

In addition, the decision below is inconsistent with an alternative antitrust analysis that the FTC applies if the medical staff does *not* control the privilege-granting process. In those circumstances, the FTC will find the requisite contract, combination, or conspiracy if the Board's concurrence is obtained by means of "explicit or implied threats of boycott or other market-distorting conduct." Winslow Paper at 17. Under this analysis, "an influential combination of competitors may not purposely disseminate misleading or deceptive information in order to 'persuade' others not to deal with the combination's competitors" (*id.* at 18); and a medical staff's use of "misinformation to induce a hospital to deny privileges to an applicant or class of applicants" is one example of conspiracy through coercion or deception. *Id.* at 18-19. Here, again, the Fourth Circuit's rejection of *Weiss* and its summary dismissal of the com-

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[15] There is abundant evidence in this case from which a jury could have found that the medical staff at Forsyth Memorial had such control. A jury would be entitled to consider that the medical staff was empowered to make the critical first determination on privilege applications (App. D at 35a, 39a-40a); that the Board acted "as an appellate body" with instructions to uphold the staff's determination unless it was "arbitrary or capricious" (*id.* at 50a); and that "[h]istorically, governing boards rarely have departed from medical staff recommendations on privilege issues." California Article at 608.

plaint would preclude consideration of such evidence.[16] This provides a further reason why this Court should review and set aside the decision below.

IV. The Court Of Appeals Departed From Accepted Standards For Summary Judgment To Such A Degree As To Seriously Imperil The Consumer Welfare Objectives Of The Antitrust Laws And To Call For The Exercise Of This Court's Power Of Supervision

Relying on *Monsanto Co. v. Spray-Rite Service Corp.*, 465 U.S. 752, 768 (1984), the court of appeals concluded that, as a matter of law, plaintiffs cannot withstand defendants' motion for summary judgment

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[16] The Winslow paper cites as one example of misinformation "overly broad generalizations about the training or expertise of a particular class of practitioners." Winslow Paper at 18 n.18. Here, a jury plainly could have found that in opposing podiatry, the orthopedic surgeons acted deceptively in failing to give due credence to the high professional standing of podiatry and that they were guilty of disseminating misinformation about podiatrists' training and expertise. For example, Dr. Rose complained that podiatrists were "not properly trained enough to be competent in caring for medical illnesses that may" arise before or after surgery. Deposition of William F. Folds, M.D. at 20. Dr. Rose failed to disclose that there would be a co-admitting M.D. who would be responsible for any such medical illness. Likewise, the Division of Medicine, in its report to the Board, expressed the "unanimous opinion, that the podiatric services that require the patient to be admitted to the hospital, would be managed better *and more safely* by a physician-surgeon, than by a Podiatrist." App. W at 151a (emphasis added). There is absolutely no factual basis for the statement that foot surgery by podiatrists is any less safe than such surgery performed by M.D. providers. The JCAH, AMA and other positions are flatly to the contrary. Likewise, there is evidence of boycott and coercion, including the orthopedic surgeons' vote that "none will supervise podiatrists in the hospital." App. S at 125a.

unless they present "evidence which 'tends to exclude the possibility of independent action.'" App. A at 6a. The court recognized that *Monsanto* is a "dealer termination" case but it nevertheless erroneously held "the *Monsanto* standard applicable in this 'group boycott' case." *Id.*

Monsanto involved a manufacturer's termination of a dealer for allegedly failing to comply with the manufacturer's resale price maintenance scheme. The sole issue was whether "an antitrust plaintiff can survive a motion for a directed verdict if it shows that a manufacturer terminated a price-cutting distributor in response to or following complaints by other distributors." 465 U.S. at 759. Emphasizing the competitive benefits that flow from the free exchange of market information between manufacturers and dealers and the legality of nonprice vertical restrictions under *Continental T.V., Inc. v. GTE Sylvania, Inc.*, 433 U.S. 36 (1977), and *United States v. Colgate & Co.*, 250 U.S. 300 (1919), this Court rejected the lower court's *post hoc ergo propter hoc* approach. *Monsanto*, 465 U.S. at 763. The Court was concerned that if "an inference of . . . an agreement may be drawn from highly ambiguous evidence, there is a considerable danger that the doctrines enunciated in *Colgate* and *Sylvania* will be eroded." *Id.* It was in this setting that the Court fashioned the stringent test of conspiracy that:

> There must be evidence that tends to exclude the possibility that the manufacturer and nonterminated distributors were acting independently.

465 U.S. at 764.

That test, which is entirely correct in a vertical restraint, rule of reason context, is entirely out of place where, as here, we are concerned with exclusionary actions by competitor groups which are always suspect and are typically *per se* illegal. *E.g.*, *Associated Press v. United States*, 326 U.S. 1, 13-19 (1945); *Silver v. New York Stock Exchange*, 373 U.S. 341, 347-49 (1963); *and see Weiss*, 745 F.2d at 815-22; Physician Control Statement at 6-7. Different conspiracy tests should apply to these very different situations.

Moreover, in *Monsanto*, this Court did not overrule *Poller v. Columbia Broadcasting System, Inc.*, 368 U.S. 464 (1962), or its holding that:

> [S]ummary procedures should be used sparingly in complex antitrust litigation where motive and intent play leading roles, the proof is largely in the hands of the conspirators, and hostile witnesses thicken the plot. It is only when the witnesses are present and subject to cross-examination that their credibility and the weight to be given their testimony can be approached. Trial by affidavit is no substitute for trial by jury which for so long has been the hallmark of "even-handed justice."

Id. at 473. Nor did this Court's recent decision in *Matsushita Electric Industrial Co., Ltd. v. Zenith Radio Corp.*, 106 S. Ct. 1348 (1986) change the *Poller* standard. The peculiar and implausible conspiracy claim in *Matsushita*[17] required that the plaintiffs, as

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[17] The alleged Japanese cartel to raise prices in Japan in order

in *Monsanto*, "come forward with more persuasive evidence to support their claims *than would otherwise be necessary*." 106 S. Ct. at 1352 (emphasis supplied).

The conspiracy and summary judgment standards fashioned by this Court in the context of a dealer termination case in *Monsanto* or an implausible predatory pricing conspiracy in *Matsushita* cannot be woodenly applied to the horizontal conspiracy of physicians alleged here. The "economic realities" of this case are far different, and they neither require, nor permit, a departure from the *Poller* standard.[18]

Under that standard, there remain in this case a number of genuine issues of material fact. What was the nature of the staff's delegated authority to determine privileges issues? Could the Board of Trustees, made up predominantly of laymen, exercise effective "appellate review" of the Staff, especially where its recommendation was based on alleged patient care considerations? Is there a legitimate quality of patient care basis to support the blanket exclusion of all podiatrists from co-admitting with a physician?

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to fund predatory prices in the U.S. over a 20-year period simply made "no economic sense" (106 S. Ct. at 1356), especially since a predatory pricing cartel is "by nature speculative" to begin with (*id.* at 1357), and it failed "to achieve its ends in two decades of its asserted operation" (*id.* at 1359).

[18] It requires little foresight to anticipate what would happen if the standard jury instruction in a horizontal conspiracy case were changed from the present form (*e.g.*, "Secrecy and concealment are common features of a successful conspiracy, and therefore, participation in a conspiracy need not be proved by direct evidence . . . [it] may be inferred from a development and putting together of circumstances") to the rule in *Monsanto* (*e.g.*, "tends to exclude the possibility" of independent action). *See* ABA, Antitrust Civil Jury Instructions at 75 (1980).

That ground is particularly inappropriate for summary disposition in light of the unanimous opposition to such blanket exclusion by the AMA, JCAH, NCHA and other medical organizations. Finally, what effect did the orthopedists' vow "to fight individually and collectively" and to boycott any supervision of podiatrists (App. S at 125a) have on the process?

In light of the strong consumer interest in greater access to hospital privileges, the lower court's decision, by precluding all scrutiny of these factual issues, imperils the central policy objective of the antitrust laws.[19] "Congress designed the Sherman Act as a 'consumer welfare prescription.'" *NCAA v. Board of Regents*, 468 U.S 85, 107 (1984); *Reiter v. Sonotone Corp.*, 442 U.S. 330, 343 (1979); R. Bork, THE ANTITRUST PARADOX at 66 (1978); I P. Areeda & D. Turner, ANTITRUST LAW ¶ 103 (1978).

If the agreements of hospital staff physicians to exclude a class of their competitors can not be exposed to examination in an antitrust trial, then consumer-patient welfare will be permanently damaged.

CONCLUSION

For all of the foregoing reasons, petitioners urge the Court to grant the writ of certiorari to review this important hospital access antitrust case.

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[19] [B]ecause staff privileges are administered primarily by physicians who are competitors of the applicant, antitrust principles apply, and their application must reflect recognition that this substantial power is probably more hazardous to competition and innovation than any other entrusted to the medical profession.

Havighurst, *Professional Restraints on Innovation and Health Care Financing*, 1978 Duke L.J. 303, 366.

Respectfully submitted,

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September 21, 1986

APPENDIX

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APPENDIX A

UNITED STATES COURT OF APPEALS FOR THE FOURTH CIRCUIT

No. 85-1385

CARLOS T. COOPER, JR., D.P.M. and
E. JOSEPH DANIELS, D.P.M.,

Appellants,

versus

FORSYTH COUNTY HOSPITAL AUTHORITY, INC.; JACK P. BARRIER, MARIAN F. BROWER, HARLEY P. GRAVES, J. CLIFTON HARPER, KAP H. HALVERSON, KENNETH A. JOHNSON, EUGENE ROSSITCH, G. DEE SMITH, ANN SPENCER, RAYMOND D. THOMAS, MARTHA J. YOUNG, WILLIAM F. FOLDS, M.D., DAVID NELSON, M.D., WILLIAM F. SAYERS, M.D. and LOUIS SHAFFNER, M.D. individually and as trustees of FORSYTH COUNTY HOSPITAL AUTHORITY; GEORGE PODGORNY, M.D.; ROBERT MEANS, M.D.; JEFF B. HELMS, M.D.; FRANK E. POLLOCK, M.D.; KENNETH G. TOMBERLIN, M.D.; JOHN T. HAYES, M.D.; RICHARD P. ROSE, M.D.; ROBERT G. UNDERDAL, M.D.; ISABEL BITTINGER, M.D.; JEROME E. JENNINGS, M.D.; The Medical Society of the State of North Carolina and North Carolina Orthopedic Association, Inc.,

Appellees,

and

CAROLYN GREEN, individually and as a trustee of Forsyth County Hospital Authority,

Defendant.

CORRECTED OPINION/PAGE 13 added

Appeal from the United States District Court for the Middle District of North Carolina, at Winston-Salem. Richard C. Erwin, District Judge. (C/A 83-75)

Argued: December 2, 1985 Decided: April 24, 1986

Before WIDENER, and ERVIN, Circuit Judges, and MOTZ, District Judge for the District of Maryland, sitting by designation.

Hamilton C. Horton, Jr. (T. Paul Hendrick; Horton, Hendrick & Kummer on brief) for Appellants; Roddey M. Ligon, Jr. (Womble, Carlyle, Sandridge & Rice); Samuel G. Thompson (John H. Anderson; Smith, Anderson, Blount, Dorsett, Mitchell & Jernigan); George L. Little, Jr. (F. Joseph Treacy, Jr.; Petree, Stockton, Robinson, Vaughn, Glaze & Maready; Thomas E. Harris; Dorie Benesh Refling; Ward and Smith, P.A.; Edward J. Westbrook; Blatt & Fales on brief) for Appellees

ERVIN, Circuit Judge

Doctor Carlos T. Cooper, Jr. and Doctor E. Joseph Daniels brought a private antitrust suit after being denied podiatric surgical privileges at Forsyth Memorial Hospital, alleging an anticompetitive conspiracy. They now appeal the district court's grant of summary judgment against them. Because appellants have failed to proffer sufficient evidence from which to infer a conspiracy, we affirm.

Doctors Cooper and Daniels are licensed podiatrists,[1] practicing in Winston-Salem, Forsyth County, North Carolina. Both perform foot surgery on an outpatient basis in their private offices. Some surgical procedures which podiatrists are licensed to perform, however, can be accomplished prudently only on an inpatient basis at a hos-

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[1] For North Carolina's podiatry licensing provisions, see N.C. Gen. Stat. §§ 90-202.2 to - 202.14 (1985).

pital. Accordingly, appellants applied for surgical privileges at Forsyth Memorial Hospital in April 1980.

The bylaws of the hospital restricted surgical privileges to members of the medical-dental staff which in turn was restricted to physicians and dentists, thus excluding podiatrists.[2] Rather than reject appellants' applications on that basis, however, a bylaws committee undertook hearings on whether the bylaws should be amended to admit podiatrists. Orthopedic surgeons with surgical privileges at the hospital participated in these hearings and objected to amending the bylaws. Orthopedists perform the majority of inpatient foot surgery at the hospital. In the event podiatrists were granted surgical privileges, podiatrists and orthopedists arguably would compete to perform certain surgical procedures.

In August 1980, the bylaws committee declined to recommend that the bylaws be amended. Because orthopedists on the medical-dental staff could perform the surgery that podiatrists sought to perform and because the education and training of orthopedists was deemed superior to that of podiatrists, the committee recommended that podiatrists continue to be excluded. Such an exclusion, they concluded, was consistent with the hospital's stated policy of providing the "best possible care."

Contemporaneous with the hospital's consideration of whether to amend the bylaws, the North Carolina Orthopedic Association (NCOA) held a general meeting in September 1980. Topics discussed at the meeting included

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[2] Therefore, whenever podiatrists had patients requiring inpatient surgery, the patients had to be referred to a surgeon with surgical privileges. Through their applications, appellants sought to be allowed to co-admit patients under the supervision of a physician, the method by which dentists admit patients. While podiatrists were excluded from the medical-dental staff and thus from surgical privileges, podiatrists are said to have "allied health" privileges, which are not clearly defined in the record.

the current status of podiatrists and the appropriate posture of NCOA toward podiatrists. The minutes of the meeting reflect that NCOA resolved to continue to oppose the granting of hospital surgical privileges to podiatrists based principally on their level of education and training. NCOA then communicated its position to its members, some of whom were orthopedists at the hospital.

Ultimately, the recommendation of the bylaws committee was adopted by the executive committee of the medical-dental staff and the board of trustees of the hospital in October 1980. The applications of appellants then were rejected summarily based upon the bylaws' restrictions.

In June 1981, the North Carolina General Assembly passed what is now N.C. Gen. Stat. § 131E-85 (Cum. Supp. 1985), establishing procedures to be followed by hospitals when granting surgical privileges.[3] That statute mentioned podiatrists, for the first time, along with physicians and dentists. With renewed optimism, appellants again applied for surgical privileges at the hospital in September 1981. Although the hospital bylaws continued to exclude podiatrists, appellants' applications were considered by the executive committee and the credentials committee of the

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[3] N.C. Gen. Stat. § 131E-85(a) provides:

> (a) The granting or denial of privileges to practice in hospitals to physicians licensed under Chapter 90 of the General Statutes, Article 1, dentists and podiatrists and the scope and delineation of such privileges shall be determined by the governing body of the hospital. Such determinations shall be based upon the applicant's education, training, experience, demonstrated competence and ability, and judgment and character of the applicant, and the reasonable objectives and regulations of the hospital, including but not limited to appropriate utilization of hospital facilities, in which privileges are sought. Nothing in this Part shall be deemed to mandate hospitals to grant or deny to any such individuals or others privileges to practice in hospitals.

This legislation was previously codified, in substantially the same language, at N.C. Gen. Stat. § 131-126.11A.

medical-dental staff and an ad hoc hearing committee, all of whom recommended denial of privileges. Subsequently the board of trustees adopted this recommendation. Appellants' applications then were denied again based on their education and training, as bearing on the quality of patient care at the hospital.

Appellants brought suit in February 1983 in the United States District Court for the Middle District of North Carolina against Forsyth County Hospital Authority, the board of trustees,[4] certain members of the medical-dental staff,[5] the Medical Society of the State of North Carolina[6] and the North Carolina Orthopedic Association.

Appellants alleged that appellees conspired, through a group boycott and a tying arrangement[7] to restrain trade in violation of § 1 of the Sherman Act. 15 U.S.C. § 1 (1982). Appellants also alleged that appellees conspired to monopolize the foot surgery market in violation of § 2 of the Sherman Act. 15 U.S.C. § 2 (1982). Finally, it was alleged that appellees violated N.C. Gen. Stat. §§ 131E-85,[8] 75-1 (1985), and 75-2 (1985)[9]. On cross motions for summary judgment, the district court granted summary judgment in favor of appellees primarily because appellants

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[4] The sixteen trustee defendants were comprised of twelve lay members and four physicians.

[5] Ten physicians were named, three of whom comprised the bylaws committee.

[6] The Medical Society is not a party to this appeal.

[7] Appellants did not pursue the tying arrangement theory on appeal.

[8] *See supra* note 3. Appellants make much of North Carolina's passage of this statute. This legislation, however, has no bearing on whether appellees conspired in violation of the Sherman Act.

[9] N.C. Gen. Stat. §§ 75-1 and 75-2 are North Carolina's version of §§ 1 and 2 of the Sherman Act.

Because we find that appellants failed to proffer sufficient evidence to maintain their federal claims, their state claims were dismissed properly for want of pendent jurisdiction.

failed to proffer sufficient evidence of an anticompetitive conspiracy. This appeal followed.

Section 1 of the Sherman Act requires proof of a "contract, combination . . ., or conspiracy, in restraint of trade." The essence of a § 1 claim is concerted action. *Terry's Floor Fashions, Inc. v. Burlington Industries, Inc.*, 763 F.2d 604, 610 (4th cir. 1985). The determinative question presented on this appeal is whether appellants have proffered sufficient evidence of a conspiracy among appellees to withstand summary judgment.[10]

Appellants have proffered no direct evidence of a conspiracy. They rely, as they may, on inferences of a conspiracy which they suggest may be drawn from circumstantial evidence. Recently, the Supreme Court, in *Monsanto Company v. Spray-Rite Service Corporation*, 465 U.S. 752 (1984), established a standard for what constitutes sufficient evidence to permit the inference of a conspiracy in antitrust cases.

> The correct standard is that there must be evidence that tends to exclude the possibility of independent action. . . . That is, there must be direct or circumstantial evidence that reasonably tends to prove . . . a conscious commitment to a common scheme designed to achieve an unlawful objective.[11]

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[10] Section 2 of the Sherman Act makes it unlawful to monopolize, to attempt to monopolize or to conspire to monopolize. 15 U.S.C. § 2. appellants, however, alleged only a conspiracy to monopolize. Because we find that appellants failed to proffer sufficient evidence of a conspiracy in violation of § 1 of the Sherman Act to withstand summary judgment, we accordingly find their § 2 claim similarly deficient.

[11] Under this standard, the Court reviewed the propriety of a directed verdict in *Monsanto*. This circuit recently has applied the *Monsanto* standard in the summary judgment context. *See Terry's Floor Fashions*, 763 F.2d at 611. While *Monsanto* and *Terry's Floor Fashions* were "dealer termination" cases, we find the *Monsanto* standard applicable in this "group boycott" case.

Monsanto, 465 U.S. at 768.

Appellants' evidence of conspiracy consists primarily of contacts and communications among the appellees. It is uncontroverted that NCOA discussed podiatry at their general meeting, that the NCOA's position regarding podiatrists was communicated to its members, that orthopedists appeared before the bylaws committee and opposed the granting of surgical privileges to podiatrists, and that the bylaws committee recommended to the board of trustees that podiatrists be denied surgical privileges. Furthermore, there is some overlap between the individuals comprising the membership of NCOA and the physician-defendants in this case.

Viewing these facts, and the inferences to be drawn from them, in the light most favorable to appellants, *see Ross v. Communications Satellite Corporation,* 759 F.2d 355, 364 (4th Cir. 1985), we find that this circumstantial evidence is not that which "reasonably tends to prove a conscious commitment to a common scheme" designed to restrain trade. *Monsanto,* 465 U.S. at 768. Nor is it evidence which "tends to exclude the possibility of independent action." *Id.* Thus, appellants' evidence is insufficient to permit the inference of a conspiracy. Indeed, the federal courts consistently have recognized that mere contacts and communications, or the mere opportunity to conspire, among antitrust defendants is insufficient evidence from which to infer an anticompetitive conspiracy in the context of the denial of hospital surgical privileges. *See Kaczanowski v. Medical Center Hospital of Vermont,* 612 F. Supp. 688, 695 (D. Vt. 1985) (podiatrists unsuccessfully challenged denial of hospital surgical privileges); *Feldman v. Jackson Memorial Hospital,* 571 F. Supp. 1000, 1007 (S.D. Fla. 1983), *aff'd,* 752 F.2d 647 (11th Cir.), *cert. denied,* 105 S. Ct. 3504 (1985) (podiatrist unsuccessfully challenged denial of hospital surgical privileges); *Robinson v. Magovern,* 521 F. Supp. 842, 892 (W.D. Pa. 1981) (thoracic surgeon unsuccessfully challenged denial of hospital

surgical privileges); *cf. Kreuzer v. American Academy of Periodontology,* 735 F.2d 1479, 1488 (D.C. Cir. 1984) (periodontist challenged "limited practice requirement" of peridontology association). To permit the inference of a conspiracy from appellants' evidence would cross the line "between reasonable inferences and mere speculation." *Terry's Floor Fashions,* 763 F.2d at 611.[12]

Not only have appellants failed to proffer evidence from which a conspiracy reasonably can be inferred, appellees have tendered affidavits denying any anticompetitive conspiracy.[13] Moreover, appellees have represented that they opposed the granting of surgical privileges to appellants on quality of patient care grounds, a legitimate reason.[14]

Because appellants' evidence does not support the inference of a conspiracy, it likewise is insufficient to raise

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[12] We recognize that there is some authority that the medical-dental staff of the hospital "is a combination of individual doctors and therefore that any action taken by the medical staff satisfies the 'contract, combination, or conspiracy' requirement of section 1 [of the Sherman Act]." *Weiss v. York Hospital,* 745 F.2d 786, 814 (3d Cir. 1984), *cert. denied,* 105 S. Ct. 1777 (1985). We question that position, but it is not necessary to resolve that issue in this case. Appellants did not allege a conspiracy among the members of the medical-dental staff.

[13] These affidavits bolster our disinclination to infer a conspiracy. *See Kreuzer,* 735 F.2d at 1488.

[14] That the challenged conduct of appellants is consistent with legitimate activities also weighs against inferring a conspiracy. *See Monsanto,* 465 U.S. at 762; *Terry's Floor Fashions,* 763 F.2d at 614; *Kruezer,* 735 F.2d at 1488. This consideration, however, must be distinguished from the affirmative defenses of "patient care motive" and "good faith." If appellants had proffered sufficient evidence to support a conspiracy, the next stage of inquiry would have considered the anticompetitive effect of appellees' conduct. In the context of the health care industry, appellees then would have had the opportunity to advance an affirmative defense of good faith or patient care motive. *See Hospital Building Company v. Trustees of Rex Hospital,* 691 F.2d 678, 686 (4th Cir. 1982); *cert. denied,* 464 U.S. 890 (1983); *Wilk v. American Medical Association,* 719 F.2d 207, 227 (7th Cir. 1983).

a genuine issue of whether appellees conspired in violation of the Sherman Act. Therefore, summary judgment against appellants was proper and the district court is affirmed.[15]

AFFIRMED.

Motz, District Judge (concurring)

Because I agree that plaintiffs did not allege a conspiracy among individual members of the medical-dental staff of the Forsyth Hospital, I concur. However, in my view Section I of the Sherman Act clearly prohibits members of a medical-dental staff from agreeing with one another to coerce a hospital's trustees to deny privileges to members of a competing profession for the purpose of furthering their economic self-interest. A jury could properly infer the existence of such an unlawful agreement from evidence of threats made to the trustees of mass resignations by the members of the medical-dental staff and the absence of demonstrably sound reasons relating to the quality of patient care underlying the defendants' actions.

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[15] We are mindful that summary judgment generally is not favored in antitrust cases. Summary judgment, however, has not been read out of antitrust litigation. *See Terry's Floor Fashions*, 763 F.2d at 610.

APPENDIX B

CARLOS T. COOPER, JR., D.P.M.,
and E. JOSEPH DANIELS, D.P.M.,

Plaintiffs,

v.

FORSYTH COUNTY HOSPITAL AUTHORITY, INC., JACK P. BARRIER, MARIAN F. BROWER, HARLEY P. GRAVES, J. CLIFTON HARPER, KAP H. HALVERSON, KENNETH A. JOHNSON, EUGENE ROSSITCH, G. DEE SMITH, ANN SPENCER, RAYMOND D. THOMAS, MARTHA J. YOUNG, Individually and as Trustees of Forsyth County Hospital Authority, Inc., and WILLIAM F. FOLDS, M.D., DAVID NELSON, M.D., WILLIAM F. SAYERS, M.D., LOUIS SHAFFNER, M.D., Individually and as Trustees of Forsyth County Hospital Authority, Inc., and GEORGE PODGORNY, M.D., ROBERT MEANS, M.D., JEFF B. HELMS, M.D., AND FRANK E. POLLOCK, M.D., KENNETH G. TOMBERLIN, M.D., JOHN T. HAYES, M.D., RICHARD P. ROSE, M.D., ROBERT G. UNDERDAL, M.D., ISABEL BITTINGER, M.D., and JEROME E. JENNINGS, M.D.,

Defendants,

and

The Medical Society of the State of North Carolina and the North Carolina Orthopedic Association, Additional Defendants.

No. C-83-75-WS.

United States District Court,
M.D. North Carolina,
Winston-Salem Division.

March 14, 1985

MEMORANDUM OPINION

ERWIN, District Judge.

Statement of the Case

This cause came on for hearing on December 21, 1984 at the United States Courthouse in Greensboro upon motions filed by all parties in the case. Plaintiffs are licensed podiatrists who are doing business in Forsyth County. In their amended complaint, plaintiffs allege that the defendants combined and conspired to restrain trade and commerce in violation of Sections 1 and 2 of the Sherman Act in that plaintiffs were denied hospital privileges. 15 U.S.C. §§ 1 and 2. Plaintiffs contend that defendants' actions constitute a group boycott and an illegal tying arrangement. Plaintiffs further allege that defendants have violated N.C. Gen. Stat. §§ 75-1 and 75-2, and N.C. Gen. Stat. § 131-126.11A. All parties have filed cross-motions for summary judgment with supporting briefs, affidavits, and exhibits.

The court finds that there is no genuine dispute as to any material facts and that this action may be disposed of by summary judgment pursuant to Rule 56 of the Federal Rules of Civil Procedure. After careful review of the extensive record compiled in this case and for the reasons stated herein, the court denies plaintiffs' partial motion for summary judgment and grants the summary judgment motions of defendants Forsyth County Hospital Authority, Inc. (Forsyth Memorial Hospital), its Trustees and Bylaws Committee, the individual defendants Pollock, Tomberlin, Hayes, Rose, Underdal, Bittinger, and Jennings, and defendant North Carolina Orthopedic Association, Inc.

Facts

Forsyth Memorial Hospital, a public general hospital with approximately 724 beds, is accredited by the Joint Commission on the Accreditation of Hospitals. The bylaws of the Medical-Dental Staff of Forsyth Memorial Hospital (Forsyth Memorial) provides: "Membership on the Medical-Dental Staff of Forsyth Memorial Hospital is a privilege

which shall be extended only to professionally competent physicians and dentists who continuously meet the qualifications, standards, and requirements set forth in these Bylaws." (Article III, Section 1.) On April 21 1980, plaintiffs applied for staff privileges at Forsyth Memorial.

After conducting hearings with respect to the question of whether or not the bylaws should be amended to allow plaintiffs to have surgical privileges, the Bylaws Committee made a report dated August 5, 1980 in which it recommended against a change in the bylaws. Thereafter, the Executive Committee of the Medical-Dental Staff voted unanimously to adopt the Bylaws Committee's recommendation. On October 14, 1980, the Board of Trustees also voted unanimously to adopt the Bylaws Committee recommendation. Additionally, the Board of Trustees referred the matter to the Joint Conference Committee which also recommended unanimously that the bylaws not be amended. The matter was returned to the Board of Trustees which renewed its recommendation.

Plaintiffs again applied for staff privileges in September 1981. On January 5, 1982, the Executive Committee and the Credentials Committee of the Medical-Dental Staff recommended the denial of plaintiffs application for clinical privileges. Hearings were held by an Ad Hoc Hearing Committee concerning plaintiffs' applications, and the Board of Trustees approved the recommendation of the Executive and Credentials Committee on February 9, 1982.

Defendants Forsyth County Hospital Authority Inc. Board of Trustees, and Bylaws Committee

Section 1 Violation—Group Boycott

Plaintiffs contend that defendants' illegal concerted actions resulting in a group boycott were the refusal to amend the bylaws to allow podiatrists to have staff priv-

ileges at Forsyth Memorial and the denial of the plaintiffs' individual applications for staff privileges at Forsyth Memorial. Defendants, on the other hand, contend that their actions were based on the good faith judgment that high quality care requires that surgery performed at Forsyth Memorial only be performed by physicians educated and trained to treat the whole person.

The standard of review for a determination of alleged antitrust violations arising out of a denial of hospital staff privileges is the "rule of reason." *See Hospital Building Company v. Trustees of Rex Hospital,* 691 F.2d 678 (4th Cir. 1983), *cert. denied,* ___U.S.___, 104 S.Ct. 231, 78 L.Ed.2d 224(1983) (No.82-1762). Thus, plaintiffs must prove that defendants' actions violated Section 1 of the Sherman Act; such violation will not be presumed. The court has carefully reviewed the transcript of the meeting of the Board of Trustees on February 9, 1982, the transcript of the meeting of the Bylaws Committee on July 9, 1980, and the transcript of the Bylaws Committee meeting on June 3, 1980, and concludes that defendants' actions were taken in good faith and were not an unreasonable restraint on trade under the circumstances.

North Carolina General Statute § 90-202.2 defines podiatry as follows: "The surgical or medical or mechanical treatment of all ailments of the human foot, except the amputation of the foot or toes or the administration of an anesthetic other than local and except the correction of clubfoot deformity and triple arthrodesis." The bylaws of Forsyth Memorial permit only allopathic physicians and dentist to become members of the Medical-Dental Staff, and only members of the Medical-Dental Staff have clinical privileges at Forsyth Memorial. After plaintiff's [sic] first application for staff privileges at Forsyth Memorial in 1980, the president of the Medical-Dental Staff appointed a Bylaws Committee. The Bylaws Committee conducted three public hearings before issuing a report recommending against a change in the bylaws.

After plaintiffs' second application for staff privileges at Forsyth Memorial in late 1981, the Credentials Committee of the Medical-Dental Staff reviewed the plaintiffs' applications individually and with particular emphasis on their education and training. The Credentials Committee recommended to the Executive Committee that plaintiffs' application for surgical and admitting privileges at Forsyth Memorial be denied. The committee advised plaintiffs, however, that the Credentials Committee would consider plaintiffs' application for non-surgical allied health privileges if plaintiffs desired to apply for such privileges. (Plaintiffs' Exhibit 15, Deposition of William F. Folds, Chairman of the Credentials Committee.) The court finds that, as the governing body of Forsyth Memorial, the Board of Trustees and its delegated committees had a duty to insure that the hospital provide quality patient care and that the actions by the Board and the Bylaws Committee were in response to this duty

Section 1 Violation—Illegal Tying Arrangement

Plaintiffs contend that defendants have engaged in an illegal typing arrangement which is a *per se* violation of Section 1 of the Sherman Act. Like the group boycott claim, plaintiffs fail to provide a factual basis for such a finding. Plaintiffs contend that the tying product is foot care at Forsyth Memorial and that the tied product is medical care rendered by orthopedists at the hospital. The United States Supreme Court in *Jefferson Parish Hospital v. Hyde*, ___U.S.___, 104 S.Ct. 1551, 1558, 80 L.Ed. 2d 2 (1984) states that "the essential characteristic of an invalid tying arrangement lies in the seller's exploitation of its control over the tying product to force the buyer into the purchase of a tied product that the buyer either did not want at all, or might have preferred to purchase elsewhere on different terms." The record is void of any evidence that defendants force patients to receive foot care only by orthopedists at Forsyth Memorial or that denying podiatrists staff privileges at Forsyth Memorial unreason-

ably restrained competition for foot care in any defined geographic market.

State Statutory Violations—N.C. Gen. Stat. §§ 75-1 and 75-2 and N.C. Gen. Stat. § 131-126.11A

Plaintiffs also allege that defendants' actions constitute violations of North Carolina "antitrust" statutes as well as the clear mandate of N.C. Gen. Stat. § 131-126.11A. For the reasons stated above as to why defendants are entitled to summary judgment on plaintiffs' claim under Sections 1 and 2 of the Sherman Act, defendants are also entitled to summary judgment under N.C. Gen. Stat. §§ 75-1 and 75-2.

Plaintiffs claim under N.C.Gen. Stat. § 131-126.11A may also be summarily dismissed. This statute, which outlines factors a governing body should consider in determining whether licensed physicians and practitioners are granted staff privileges at a hospital, also includes the proviso: "Nothing in this article shall be deemed to mandate hospitals to grant or deny to any parties privileges to practices in said hospitals." Plaintiffs have failed to demonstrate in any manner that defendants disregarded the factors to be considered in denying plaintiffs staff privileges at Forsyth Memorial. Without such a showing, no violation of N.C. Gen. Stat. § 131-126.11A exists.

Defendant North Carolina Orthopedic Association

Defendant North Carolina Orthopedic Association, Inc. (Association) is a statewide, non-profit corporation which meets twice a year. In October 1975, the Association adopted a resolution opposing the practice of podiatry in a hospital setting in response to a report on podiatry legislation. In 1984, the Association formally adopted the position that the hospital practice of podiatry be determined at the local level. Plaintiffs contend that the Association combined and conspired with the other defendants to com-

mit a violation of Sections 1 and 2 of the Sherman Act, Sections 75-1 and 75-2 of the North Carolina General Statutes, and the clear mandate of North Carolina General Statute § 131-126.11A. Thus, defendant North Carolina Orthopedic Association's presence in this lawsuit is purely on the basis of its alleged conspiratorial activities. The court finds, however, that although plaintiffs attempt to show that the Association met on several occasions and discussed the issue of podiatrists gaining hospital staff privileges, this evidence in itself is insufficient to support a reasonable inference of any conspiracy.

The individual orthopedic defendants have filed affidavits denying that they engaged in any conspiratorial conduct with the Board of Trustees of Forsyth Memorial Hospital or any other defendant. In their affidavits, these defendants explain why they opposed a change in the hospital's bylaws and that they were not representing the Association in their opposition to a change in the bylaws. As the United States Supreme Court in *Monsanto Co. v. Spray-Rite Service Corp.*, ___U.S.___, 104 S. Ct. 1464, 79 L. Ed. 2d 775 (1984), noted, there is a basic distinction between concerted and independent action; independent action is not proscribed under Section 1 of the Sherman Act. In order to prevail on a conspiracy claim, plaintiffs must present evidence that "excludes the possibility that [defendants] were acting independently." ___U.S. at ___ 104 S. Ct. at 1471. The court finds that plaintiffs have failed to establish any evidence of a conspiracy on the part of the Association with any other defendants and that defendant North Carolina Orthopedic Association is entitled to summary judgment on all claims as a matter of law.

Defendants Pollock, Tomberlin, Hayes, Rose, Underdal, Bittinger, and Jennings

Plaintiffs allege that these individual defendants are allopathic physicians who specialize in orthopedics and who compete with plaintiffs in the treatment of the feet. Also, these defendants have staff privileges at Forsyth Memorial. The court has found that no conspiracy existed against plaintiffs to deny them staff privileges at Forsyth Memorial. Accordingly, these defendants are also entitled to summary judgment on all plaintiffs' claims as a matter of law.

Based on the foregoing, IT IS HEREBY ORDERED, ADJUDGED, AND DECREED that the summary judgment motions of defendants Forsyth County Hospital Authority, Inc., its Trustees and Bylaws Committee; individual defendants Pollock, Tomberlin, Hayes, Rose, Underdal, Bittinger, and Jennings; and defendant North Carolina Orthopedic Association, Inc. are GRANTED.

IT IS FURTHER ORDERED, ADJUDGED, AND DECREED that plaintiffs' motion for partial summary judgment is DENIED. In view of the court's rulings, defendants' motion to strike is denied as moot. A judgment will be entered contemporaneously with this Memorandum Opinion dismissing this action with prejudice as to all defendants. All parties are to bear their own costs.

APPENDIX C

IN THE UNITED STATES DISTRICT COURT FOR THE MIDDLE DISTRICT OF NORTH CAROLINA WINSTON-SALEM DIVISION

Civil Action No. C-83-75-WS

CARLOS T. COOPER, JR., D.P.M., and E. JOSEPH DANIELS, D.P.M.

Plaintiffs,

vs.

FORSYTH COUNTY HOSPITAL AUTHORITY, INC., JACK P. BARRIER, MARIAN F. BROWER, HARLEY P. GRAVES, J. CLIFTON HARPER, KAP H. HALVERSON, KENNETH A. JOHNSON, EUGENE ROSSITCH, G. DEE SMITH, ANN SPENCER, RAYMOND D. THOMAS, MARTHA J. YOUNG, INDIVIDUALLY and as TRUSTEES OF FORSYTH COUNTY HOSPITAL AUTHORITY, INC.,
and

WILLIAM F. FOLDS, M.D., DAVID NELSON, M.D., WILLIAM F. SAYERS, M.D., LOUIS SHAFFNER, M.D., INDIVIDUALLY and as TRUSTEES OF FORSYTH COUNTY HOSPITAL AUTHORITY, INC.,
and

GEORGE PODGORNY, M.D., ROBERT MEANS, M.D., JEFF B. HELMS, M.D.,
and

FRANK E. POLLOCK, M.D., KENNETH G. TOMBERLIN, M.D., JOHN T. HAYES, M.D., RICHARD P. ROSE, M.D., ROBERT G. UNDERDAL, M.D., ISABEL BITTINGER, M.D., and JEROME E. JENNINGS, M.D.,

Defendants,

and

THE MEDICAL SOCIETY OF THE STATE OF NORTH CAROLINA and THE NORTH CAROLINA ORTHOPEDIC ASSOCIATION,
Additional Defendants.

FILED
AUGUST 19, 1983

AMENDED COMPLAINT
JURY TRIAL DEMANDED

The plaintiffs allege:

I
JURISDICTION AND VENUE

1. This is an action grounded on anti-trust and this court therefore has jurisdiction under 28 USC § 1337 and 15 USC § 15. Violation of Chapters 75 and 131 of the N.C. General Statutes is also alleged and this court has pendant jurisdiction of that claim.

2. The defendants and each of them transact business and are found within the State of North Carolina and the unlawful actions and violations described were carried out principally within the Middle District of North Carolina, Winston-Salem Division. Venue is therefore invoked pursuant to 28 USC § 1391 and 15 USC § 15. The interstate commerce described herein is carried out in part within the Middle District of North Carolina.

II
PARTIES

3. The plaintiffs are citizens and residents of Forsyth County, North Carolina, and Doctors of Podiatric Medicine, duly licensed by the State of North Carolina.

4. The defendant Forsyth County Hospital Authority, Inc. is a corporation organized under the provisions of G.S.

Chapter 55A with its principal place of business in Forsyth County, North Carolina, and operating as its principal business Forsyth Memorial Hospital, a general acute public hospital of some 724 beds in Winston-Salem.

5. The defendants Barrier, Brower, Graves, Green, Harper, Halverson, Johnson, Rossitch, Smith, Spencer, Thomas and Young are citizens and residents of Forsyth County and were lay members of the Board of Trustees, the governing body of the Forsyth County Hospital Authority, Inc. at all times pertinent hereto. The defendants Folds, Nelson, Sayers and Shaffner are allopathic physicians who are citizens and residents of Forsyth County and were members of the Board of Trustees of the Forsyth County Hospital Authority, Inc. at all times pertinent hereto.

6. The defendants Podgorny, Means and Helms are allopathic physicians who are citizens and residents of Forsyth County, members of the Medical-Dental Staff of Forsyth Memorial Hospital, and were members of a bylaws committee appointed by the President of the Medical-Dental Staff at all times pertinent hereto. As such, these defendants refused to recommend an amendment to the bylaws of the Medical-Dental Staff of Forsyth Memorial Hospital which would permit podiatrists to become members of that staff.

7. The defendants Pollock, Tomberlin, Hayes, Rose, Underdal, Bittinger and Jennings are allopathic physicians who specialize in orthopedics and as such compete with plaintiffs in the market area relevant to this action. They are defendants not only because they have actively opposed allowing podiatrists to treat patients in Forsyth Memorial Hospital but also as representatives of those allopathic physicians who compete with plaintiffs in the treatment of the feet and who monopolize access to the facilities of Forsyth Memorial Hospital.

7(a). The additional defendant Medical Society of North Carolina is a body politic and corporation established by

N.C.G.S. 90-1, with its corporate offices in Wake County. The additional defendant North Carolina Orthopedic Association, as plaintiffs are informed, believe and therefore allege, is a voluntary and unincorporated association of allopathic physicians who hold themselves out as specialists in the medical field of orthopedics within the State of North Carolina, including Forsyth County.

III

INTERSTATE COMMERCE

8. The corporate defendant is licensed by the State of North Carolina through the North Carolina Department of Human Resources pursuant to Chapters 121 and 125 of the General Statutes of North Carolina. It operates Forsyth Memorial Hospital which accepts and provides medical treatment to patients from North Carolina, Virginia, and from other states, receives substantial payments through the federal Medicare and Medicaid programs, purchases medicines, equipment and supplies from vendors in other states, receives substantial payments from insurors in other states, and plaintiffs are informed, believe and therefore allege has continuing contractual arrangements with entities in other states than North Carolina, all of which affect interstate commerce.

9. The plaintiffs treat patients from North Carolina and other states, and because of the acts complained of hereinafter, travel perforce from, time to time to states which permit them to treat these patients in a hospital setting. They purchase substantial amounts of equipment, medicine and supplies from out-of-state sources, receive Medicare and Medicaid payments through the Federal Government on behalf of a significant number of patients, and receive substantial insurance payments from out-of-state insurors, all of which affect interstate commerce.

IV

RELEVANT MARKET

10. Forsyth Memorial Hospital is the largest public general hospital in North Carolina, affording approximately 724 beds for patients. The average bed census is 641, for an occupancy rate of 88.5%. In Forsyth County it is the only public hospital to which plaintiffs could admit patients, since North Carolina Baptist Hospital is an allopathic teaching hospital the staff of which is composed solely of faculty of the Bowman Gray School of Medicine, and Forsyth Medical Park Hospital, with only 136 beds, is a private hospital operated by a for-profit partnership.

Accordingly, Forsyth Memorial Hospital and its staff occupy a monopoly status within Forsyth County and the larger area to the north and west from which the said hospital attracts business: those physicians and surgeons who are not faculty members of Bowman Gray School of Medicine must be members of the Medical-Dental Staff of Forsyth Memorial Hospital if they are to have access to operating rooms, intensive and cardiac care facilities, radiology, blood bank, pathology, and the services of anesthesiologists and trained nursing assistants. In 1981, slightly more than 80% of all admissions to hospitals (other than North Carolina Baptist Hospital) in Forsyth County were admissions to the Forsyth Memorial Hospital, the other admissions being to Forsyth Medical Park, a proprietary private hospital. In 1981, 100% of all admissions to non-teaching public hospitals, were admissions to Forsyth Memorial Hospital.

11. The relevant market area in this cause of action is Forsyth County with a 1980 census of 243,683. While many customers come from the counties north and west of Forsyth, and from southwestern Virginia, very few residents of Forsyth County go elsewhere for medical treatment.

Within this relevant market Forsyth Memorial Hospital is the sole acute non-teaching public hospital to which physicians and surgeons in private practice can admit their patients were admissions to Forsyth Memorial Hospital.

V

FACTUAL BACKGROUND

12. Podiatry is defined by North Carolina General Statutes 90-202.2 as

> "The surgical or medical or mechanical treatment of all ailments of the human foot, except the amputation of the foot or toes or the administration of an anesthetic other than local and except the correction of clubfoot deformity and triple arthrodesis."

The profession of podiatry, together with those of allopathic medicine, dentistry and osteopathy, constitute the only health professions allowed by law to treat independently, prescribed [sic] drugs and perform surgery.

13. The plaintiff E. Joseph Daniels is a Podiatrist duly licensed under Article 12A of Chapter 90 of the North Carolina General Statutes and has practiced his profession in the State of North Carolina since 1967. He is a graduate of Wake Forest University and the Ohio College of Podiatric Medicine, has pursued a Residency at the Cleveland Foot Clinics, is a member of the American College of Foot Surgeons, and a member of the American Board of Podiatric Surgeons in the Board Eligible category. He is a Diplomate of the National Board of Podiatric Examiners, and a member of the North Carolina State Board of Podiatric Examiners. Dr. Daniels has written and presented scientific papers and lectures to various professional meetings and has performed more than 5,200 surgical procedures.

14. The plaintiff Carlos T. Cooper, Jr. is a Podiatrist duly licensed under Article 12A of Chapter 90 of the North Carolina General Statutes and has practiced his profession in the State of North Carolina since 1954. He is a graduate of Wake Forest University and the Ohio College of Podiatric Medicine, and has done additional study in the fields of Physiology and Pharmacology at Bowman Gray School of Medicine. He is a member of the American Board of Podiatric Surgery in the Board Eligible category, has instructed in podiatry at the California College of Podiatric Medicine and has been an adjunct clinician with the Ohio College of Podiatric Medicine. He has written and presented papers and lectures at various professional meetings and has averaged more than 400 surgical procedures each year for the past decade. Dr. Cooper is a member of the North Carolina State Board of Podiatric Examiners.

15. While G.S. 90-202.2 specifically authorizes plaintiffs to perform surgery on the foot, the bylaws of Forsyth Memorial Hospital permit only allopathic physicians and dentists to become members of the Medical-Dental Staff, and therefore to have the privilege of admitting patients to that public hospital, since only members of the Medical-Dental Staff have clinical privileges at Forsyth Memorial Hospital.

16. The lack of staff privileges and the consequent right to admit patients to Forsyth Memorial Hospital for surgical care as aforesaid has required plaintiffs to construct and equip operating rooms in their own offices and provide their own trained surgical assistants, instruments, and sterile areas all at considerable expense while their competitors who are members of the staff of Forsyth Memorial Hospital have all these things provided by said hospital. Additionally, numbers of podiatric patients who prefer the services of plaintiffs cannot be treated by them because of the patients' physical condition which requires, in good medical practice, hospital facilities such as cardiac care, anesthesiology, recovery rooms and the other services af-

forded by an acute hospital such as Forsyth Memorial Hospital. These patients must be directed by plaintiffs to their allopathic competition for treatment since only allopathic physicians are members of the medical staff at Forsyth Memorial Hospital.

17. Podiatrists are a definite and identifiable class who share the same professional, educational and business characteristics within the relevant market. Their right to practice their chosen occupation and to have patients engage their professional services are privileges and immunities and property interests which are protected by the 5th and 14th amendments to the United States Constitution. Hospital privileges, including surgical privileges, are essential to the exercise of their right to practice their profession and to treat those patients who request their services.

18. Forsyth Memorial Hospital is accredited by the Joint Commission on the Accreditation of Hospitals (JCAH). The JCAH specifically states "Podiatrists who are appropriately licensed may be granted clinical privileges that are based on their documented training, experience, and current competence" within the limits of their field.

19. The American Medical Association supports "the extension of practice privileges in hospitals to qualified, licensed podiatrists in accordance with their training, experience and demonstrated competence and judgment. . ." [sic]

20. The North Carolina Hospital Association, of which Forsyth Memorial Hospital is a member, on February 1, 1980, wrote each member institution suggesting that their bylaws be changed to allow clinical privileges to licensed podiatrists "based on his training, experience, and current demonstrated competence and judgment" and providing detailed recommendations for other changes in the member-hospitals' bylaws to accommodate clinical privileges for doctors of podiatric medicine.

21. On or about April 21, 1980, plaintiffs applied for staff privileges at Forsyth Memorial Hospital, providing said hospital at that time a copy of the North Carolina Hospital Association memorandum referred to in paragraph 20 above.

22. At all times pertinent hereto, the bylaws of the Medical-Dental Staff of Forsyth Memorial Hospital, duly approved by the Board of Trustees of the Forsyth County Hospital Authority, provided in Article III, Section 1, "membership on the Medical-Dental Staff of Forsyth Memorial Hospital is a privilege which shall be extended only to . . . physicians and dentists. . .".

23. After receipt of plaintiffs' application a Bylaws Committee consisting of the defendants Podgorny, Means and Helms was appointed by the President of the Medical-Dental Staff. Three public hearings were held at which defendants Pollock, Tomberlin, Hayes, Rose, Underdal, Bittinger and Jennings appeared and argued against changing the bylaws to permit the admission of a podiatrist to the Medical-Dental Staff. Defendants Pollock, Tomberlin, Hayes, Rose, Underdal, Bittinger and Jennings are orthopedists who compete with plaintiffs in the care of the feet within the relevant market.

24. The Bylaws Committee report dated August 5, 1980, annexed hereto as Exhibit A, recommended against a change in the bylaws of the Medical-Dental Staff, thus recommending in favor of a continuation of the exclusion of podiatrists as a class from clinical privileges at Forsyth Memorial Hospital. The recommendation of the Bylaws Committee was based in part on the fact that Forsyth Memorial Hospital had orthopedists already on its staff, and that these orthopedists treated the same medical problem as those treated by podiatrists.

25. Thereafter the Executive Committee of the Medical-Dental Staff voted unanimously to adopt the Bylaws Committee recommendation, thus favoring a continuation of

the exclusion of podiatrists as a class from clinical privileges at Forsyth Memorial Hospital.

26. Thereafter the Board of Trustees on October 14, 1980, at a meeting attended by numbers of members of the Medical-Dental Staff and at which a request for a secret ballot was denied, voted unanimously to adopt the Bylaws Committee recommendation, thus favoring a continuation of the exclusion of podiatrists as a class from clinical privileges at Forsyth Memorial Hospital.

27. Thereafter the United States Department of Health and Human Resources, Division of Hospital Services, on October 17, 1980, ruled "a hospital that has policies or selection criteria which excludes podiatrists from consideration would not be in compliance with Medicare requirements."

28. On June 23, 1981, following the recommendation of the State of North Carolina's Governmental Evaluation Commission that podiatrists should be permitted to perform in a hospital setting those operations they are already licensed to perform by law, the North Carolina General Assembly passed legislation, Chapter 659 of the 1981 Session laws, now codified as part of the "Hospital Licensing Act", G.S. 131-126.11A as follows:

> "The granting or denial of privileges to practice in hospitals to licensed physicians and other practitioners licensed by the State of North Carolina to practice surgery on human beings, and the scope and conditions of such privileges, shall be determined by the governing body of the hospital based upon the applicant's education, training, experience, demonstrated competence and ability, judgment, character and the reasonable objectives and regulations of the hospital in which such privileges are sought. Nothing in this article shall be deemed to mandate hospitals to grant or deny

> to any parties privileges to practice in said hospitals."

The avowed purpose of this legislation was to require the allowance of staff privileges for qualified podiatrists in the hospitals of North Carolina.

29. On September 25, 1981, plaintiffs again applied for membership on the staff of Forsyth Memorial Hospital, this time attaching a copy of the statute referred to in paragraph 28.

30. On January 5, 1982, the Credentials Committee of the Medical-Dental Staff, having had read to them G.S. 131-126.11A, and reciting the identical reasons as those stated by the Bylaws Committee on August 5, 1980, recommended that the applications of the plaintiffs for clinical privileges be denied.

31. Also on January 5, 1982, and again reciting the same reasons as those stated on August 5, 1980, the Executive Committee denied the plaintiffs' applications for clinical privileges, thus again excluding podiatrists as a class from access to Forsyth Memorial Hospital to treat their patients.

32. An ad hoc Hearing Committee appointed by the President of the Medical-Dental Staff heard plaintiffs' appeals of the decision of the Executive Committee on February 2, 1982. This Committee also recommended that plaintiffs' applications for clinical privileges be denied.

33. On or about January 11, 1982, each member of the Board of Trustees of the defendant Forsyth County Hospital Authority had been advised of the enactment of G.S. 131-126.11A by the 1981 General Assembly and advised further of possible statutory, constitutional and anti-trust implications of an exclusion of podiatrists as members of the Medical-Dental Staff.

34. On February 9, 1982, nevertheless, the Board of Trustees endorsed and approved the recommendations of

the Credentials and Executive Committees of the Medical-Dental Staff attached hereto as Exhibit B, and reciting in part that "permitting podiatrists to have admitting and surgical privileges would be inconsistent with the statement of the purpose of the Medical-Dental Staff of the hospital which is to provide patients with the best possible care" and noting as a reason "Forsyth Memorial Hospital has several orthopedic surgeons on its staff all capable of fulfilling the functions performed by a podiatrist as well as the ability to treat the entire patient."

35. Immediately thereafter, and fully aware of North Carolina General Statutes 131-126.11A, the Board of Trustees passed a resolution authoritizing the "hospital to defend, indemnify and hold harmless its Trustees, Administrators and Medical-Dental Staff members against the threatened litigation by podiatrists who have had, or may have, their applications for admitting and surgical privileges at Forsyth Memorial Hospital denied."

36. The actions of the defendants jointly and severally, as detailed in the foregoing paragraphs have denied podiatrists as a group, and these plaintiffs in particular, the right to practice their profession in the only public acute hospital available to them in the relevant market, while guaranteeing their competitors a continuing monopoly of access to hospital facilities in the relevant market. The plaintiffs are informed, believe and therefore allege that at no time in the processing of any of plaintiffs' applications did the defendants investigate and consider the plaintiffs' individual education, training, experience, demonstrated competence and ability, nor their judgment and character.

36(a). Plaintiffs are informed, believe and therefore allege that the additional defendants have combined and conspired with the original defendants to refuse to amend the by-laws of the Medical Dental Staff to permit podiatrists to become members of the Staff at the defendant

hospital, and have combined and conspired with the original defendants to oppose the admission of plaintiffs to the Staff at the defendant hospital. Specifically, the additional defendant Medical Society has co-ordinated its efforts with those of the additional defendant Orthopedic Association to oppose staff privileges for podiatrists throughout North Carolina in order to establish and maintain a monopoly for allopathic physicians as to patients who require or desire treatment of their feet in a hospital setting. A majority of the original defendants in this action are members of the Orthopedic Association or the Medical Society, or both, and plaintiffs are informed, believe and therefore allege that their actions have been inspired, influenced and directed by the long standing efforts of the additional defendants against staff privileges for podiatrists.

VI

VIOLATIONS ALLEGED

37. The additional defendants and the defendants who are allopathic physicians conspired and combined with the Trustees of the corporate defendant to violate the mandate of North Carolina General Statutes 131-126.11A requiring that plaintiffs be considered for staff membership on their individual merits and that they not be excluded simply because they were practitioners of podiatric medicine.

38. The defendants violated Section 2 of the Sherman Act (15 USC § 2) in that they conspired and combined to foreclose plaintiffs from access to the market for patients who desire care and treatment for their feet in a hospital setting.

39. The defendants combined and conspired to restrain trade and commerce by denying the plaintiffs hospital privileges, thus participating in group boycott and foreclosing access by plaintiffs to the market, and engaging in a concerted refusal to deal with the plaintiffs, all of which is in violation of §§ 1 and 2 of the Sherman Act and in

further violation of the prohibition of Sections 75-1 and 75-2 of the General Statutes of North Carolina.

40. The defendants have combined and conspired to create and perpetuate a monopoly in the provision of hospital care for those desiring and needing medical attention to the feet, all with the intention of monopolizing the relevant market and depriving consumers of the befits [sic] of free competition in violation of Section 1 of the Sherman Act (15 USC § 1) and Article I, § 34 of the Constitution of North Carolina.

41. The defendants have combined and conspired to establish and maintain a system of tie-in sales whereby no potential patient for foot care in the relevant market can receive such care in the only available public hospital without also consenting to having his medical care rendered by a competitor of plaintiffs, in violation of Sections 1 and 2 of the Sherman Act.

42. The defendants have combined and conspired to violate the clear mandate of G.S. 121-126.11 for purposes of their own economic gain, contrary to the purposes of enhanced competition and access to the relevant market by all qualified practitioners, as expressed by the North Carolina General Assembly.

VII

PER SE VIOLATIONS

43. The violations alleged in paragraphs 38, 39 and 41 are per se violations of the Anti-trust laws of the United States.

VIII

DAMAGES AND ALLEGATIONS OF THREATENED CONTINUING IRREPARABLE DAMAGE

44. As a result of the defendants' actions, the plaintiffs have suffered and continue to suffer a substantial loss of

income from their practices, increased costs of doing business in that they must provide staff, operating rooms and equipment which would otherwise be provided by the corporate defendant, have lost patients who would have sought their services were they able to provide them in a hospital setting, and have suffered loss of professional reputation, embarrassment and humiliation due to the implication that, since they are not permitted to perform in corporate defendant's hospital those clinical privileges which North Carolina Statutes expressly permit, they are incompetent professionally by comparison to their competitors among the allopathic physicians and especially those orthopedic surgeons who currently monopolize access to the only available, public hospital in a relevant market.

45. The corporate defendant and the individual defendants have been and threaten to remain intransigent in their refusal to obey the laws of the State of North Carolina passed for the express purpose of assuring that plaintiffs and those in their class of practitioners should be given the right to be considered for clinical privileges in public hospitals based on their individual training, experience, competence and judgment. Indeed, the corporate and individual defendants have had two opportunities to comply with the standards established by the JCAH, the AMA, the North Carolina Hospital Association, the U.S. Department of Health and Human Resources, and the General Statutes of North Carolina, and having been explicitly advised of said standards, have persisted in refusing to comply with them.

They threaten to continue to operate Forsyth Memorial Hospital as a monopoly within the relevant market, and to continue to deny hospital staff privileges to plaintiffs solely because they are podiatrists. They threaten to continue their boycott, their concerted refusal to deal, their unfair trade practices, and their tied-sales of medical services and, if not restrained, there is a substantial probability that plaintiffs will suffer immediate, irreparable and

irremediable damage in that these unlawful business practices by the defendants will continue to diminish the business of the plaintiffs, continue to cause them additional burdensome expenses which place them in an unfair competitive position, and will continue to deny patients within the relevant market access to the services of the providers of foot care they choose.

IX

AD DAMNUM

WHEREFORE, Plaintiffs pray that the Court:

1. Enter a preliminary and permanent mandatory injunction requiring the defendants to admit the plaintiffs to hospital privileges at Forsyth Memorial Hospital in accordance with the scope of their practice and with the standards set out by the JCAH, the AMA, the North Carolina Hospital Association, the United States Department of Health and Human Resources and the General Statutes of North Carolina.

2. Enter a preliminary and permanent injunction enjoining defendants from continuing their combination and conspiracy against the class of practitioners represented by plaintiffs and requiring that duly licensed podiatrists be considered for clinical privileges at Forsyth Memorial Hospital based on their training, experience, competence and judgment.

3. Permit the plaintiffs to recover of the defendants jointly and severally, the amount of actual damages suffered by the plaintiffs because of the unlawful acts of the defendants, which damages cannot be with certainty ascertained at this time but which exceed $250,000.00 for each plaintiff.

4. That such damages be trebled in accordance with the law by the Court.

5. That the plaintiffs be awarded reasonable attorneys fees.

6. That the attempt of the defendants to require Forsyth Memorial Hospital, and thus the patients therein, to indemnify and hold them harmless for their unlawful acts be declared against public policy and null and void.

7. That the Court award the plaintiffs such other and further relief as to the Court may seem just.

8. That plaintiffs be awarded trial by a jury of their peers.

This 2nd day of August, 1983.

/s/ T. PAUL HENDRICK
T. Paul Hendrick
Attorney for Plaintiffs

/s/ HAMILTON C. HORTON, JR.
Hamilton C. Horton, Jr.
Attorney for Plaintiffs

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APPENDIX D

BYLAWS OF THE MEDICAL-DENTAL STAFF OF FORSYTH MEMORIAL HOSPITAL

PREAMBLE

WHEREAS, Forsyth Memorial Hospital is a non-profit corporation organized under the laws of the State of North Carolina; and

WHEREAS, its purpose is to serve as a general hospital providing patient care, medical education and research; and

WHEREAS, it is recognized that the Medical-Dental Staff is responsible for the quality of medical care in the Hospital and must accept and discharge this responsibility, subject to the ultimate authority of the Board of Trustees of the Forsyth County Hospital Authority, Inc. (Governing Body), and that the cooperative efforts of the Medical-Dental Staff, the Chief Executive Officer, and the Governing Body are necessary to fulfill the Hospital's obligations to its patients;

THEREFORE, the physicians and dentists practicing in this Hospital hereby organize themselves into a Medical-Dental Staff in conformity with these Bylaws. Also, these Bylaws shall be applicable to all physicians or dentists who are required to be members of the Medical-Dental Staff of Forsyth Memorial Hospital in order to perform services at another institution.

DEFINITIONS

(1) The term "practitioner" means a physician or dentist licensed to practice in the State of North Carolina.

(2) The term "medical-dental staff" means all duly licensed physicians and dentists who are privileged to attend patients in the Hospital.

(3) The term "governing body" means the Board of Trustees of the Forsyth County Hospital Authority, Inc.

(4) The term "executive committee" means the Executive Committee of the Medical-Dental Staff unless reference is made to the Executive Committee of the Governing Body.

* * * *

ARTICLE I: NAME

The name of this organization shall be the Medical-Dental Staff of Forsyth Memorial Hospital.

ARTICLE II: PURPOSES

The purposes of this organization are:

(1) To insure that all patients admitted to or treated in any of the facilities, departments, or services of the Hospital shall receive the best possible care;

(2) To insure a high level of professional performance of all practitioners authorized to practice in the Hospital through the appropriate delineation of the clinical privileges that each practitioner may exercise in the Hospital and through continuing review and evaluation of each practitioner's performance in the Hospital;

(3) To provide an appropriate educational setting that will maintain scientific standards and that will lead to continuous advancement in professional knowledge and skill;

(4) To initiate and maintain rules and regulations for self-government of the Medical-Dental Staff; and

(5) To provide a means whereby issues concerning the Medical-Dental Staff and the Hospital may be discussed

by the Medical-Dental Staff with the Governing Body and the Chief Executive Officer.

Insofar as these Bylaws, and the Rules and Regulations contained herein, relate to patient care they are to be considered as a recommendation that Staff members strive for optimum patient care and treatment during the hospitalization of a patient at Forsyth Memorial Hospital, and are not to be interpreted as the standard or an any indicia of standards specifying the duties or outlining the requirements of Hospital or Staff personnel in the care and treatment of patients.

ARTICLE III: MEDICAL-DENTAL STAFF MEMBERSHIP

Section 1. Nature of Medical-Dental Staff Membership.

Membership on the Medical-Dental Staff of Forsyth Memorial Hospital is a privilege which shall be extended only to professionally competent physicians and dentists who continuously meet the qualifications, standards, and requirements set forth in these Bylaws.

Section 2. Qualifications for Membership.

(a) Only physicians and dentists licensed to practice in the State of North Carolina, who can document their background, experience, training, and demonstrated competence, their adherence to the ethics of their profession, their good reputation, and their ability to work with others, with sufficient adequacy to assure the Medical-Dental Staff and the Governing Body that any patient treated by them in the Hospital will be given a high quality of medical care, shall be qualified for membership on the Medical-Dental Staff. No physician or dentist shall be entitled to membership on the Medical-Dental Staff or to the exercise of particular clinical privileges in the Hospital merely by virtue of the fact that he is duly licensed to practice medicine or dentistry in this or in any other state, or that he

is a member of any professional organization, or that he had in the past, or presently has, such privileges at another hospital.

* * * *

Section 3. Conditions and Duration of Appointment.

(a) Initial appointments and reappointments to the Medical-Dental Staff shall be made by the Governing Body. The Governing Body shall act on appointments, reappointments, or revocation of appointments only after there has been a recommendation from the Medical-Dental Staff as provided in these Bylaws, provided that in the event of unwarranted delay on the part of the Medical-Dental Staff, the Governing Body may act without such recommendation on the basis of documented evidence of the applicant's or staff member's professional and ethical qualifications obtained from reliable sources.

(b) Initial appointments shall be for a period extending to the end of the current Hospital year. Reappointments shall be for a period of not more than one Hospital year.

(c) Appointment to the Medical-Dental Staff shall confer on the appointee only such clinical privileges as have been granted by the Governing Body, in accordance with these Bylaws.

(d) Every application for staff appointment shall be signed by the applicant and shall contain the applicant's specific acknowledgement of every Medical-Dental Staff member's obligation to provide care and supervision of his patients, and to abide by the Medical-Dental Staff Bylaws, Rules and Regulations, and the Bylaws of the Forsyth County Hospital Authority, Inc.

ARTICLE IV: CATEGORIES OF THE MEDICAL-DENTAL STAFF

* * * *

ARTICLE V: PROCEDURE FOR APPOINTMENT AND REAPPOINTMENT

Section 1. Application for Appointment.

(a) All applications for appointment to the Medical-Dental Staff shall be in writing, shall be signed by the applicant, and shall be submitted on a form prescribed by the Governing Body after consultation with the Executive Committee. The application shall require detailed information concerning the applicant's professional qualifications, shall include the names of at least two persons who have had extensive experience in observing and working with the applicant and who can provide adequate references pertaining to the applicant's professional competence, ethics, and character, and shall include information as to whether the applicant's membership status and/or clinical privileges have ever been revoked, suspended, reduced, or not renewed at any other hospital or institution, and as to whether his membership in local, state, or national medical societies or his license to practice any profession in any jurisdiction, has ever been suspended or terminated.

(b) The applicant shall have the burden of producing adequate information for a proper evaluation of his professional competence, character, ethics, and other qualifications, and for resolving any question about such qualifications.

(c) The completed application shall be submitted to the Chief Executive Officer, who, after collecting the references and other materials deemed pertinent, shall transmit the application and all supporting materials to the Credentials Committee for evaluation.

* * * *

Section 2. Appointment Process.

(a) Within thirty (30) days after receipt of the completed application for membership, the Credentials Committee

shall make a written report of its investigation to the Executive Committee. Prior to making this report, the Credentials Committee shall examine the evidence of the character, professional competence, qualifications, and ethical standing of the practitioner and shall determine, through information contained in references given by the practitioner and from other sources available to the committee, including the appraisal from the Division or Department in which privileges are sought, whether the practitioner has established and meets all of the necessary qualifications for the category of Staff membership and the clinical privileges requested by him. Every Division or Department in which the practitioner seeks clinical privileges shall provide the Credentials Committee with specific, written recommendations for delineating the practitioner's clinical privileges, and these recommendations shall be made a part of the report.

The Division of Family Practice may make recommendations to the other clinical Divisions or Sections for privileges for individual members of the Division. The Division of Family Practice may also assist its members in their applications for privileges in other specialty Divisions or Sections and in such other matters as will insure the highest possible level of patient care.

Together with its report, the Credentials Committee shall transmit to the Executive Committee the completed application and a recommendation that the practitioner be either provisionally appointed to the Medical-Dental Staff or rejected for Medical-Dental Staff Membership, or that the application be deferred for further consideration.

(b) At its next regular meeting after receipt of the application and the report and recommendation of the Credentials Committee, the Executive Committee shall determine whether to recommend to the Governing Body that the practitioner be provisionally appointed to the Medical-Dental Staff, that he be rejected for Medical-Dental

Staff membership, or that his application be deferred for further consideration. All recommendations for appointment must also recommend the specific clinical privileges to be granted, which may be qualified by probationary conditions relating to such clinical privileges.

(c) When the recommendation of the Executive Committee is to defer the application for further consideration, it must be followed up within thirty (30) days with a subsequent recommendation for provisional appointment with specified clinical privileges or for rejection for Staff membership.

(d) When the recommendation of the Executive Committee is favorable to the practitioner, the Chief Executive Officer shall promptly forward it, together with all supporting documentation, to the Governing Body.

(e) When the recommendation of the Executive Committee is adverse to the practitioner either in respect to appointment or clinical privileges, the Chief Executive Officer shall promptly so notify the practitioner by certified mail, return receipt requested. No such adverse recommendation need be forwarded to the Governing Body until after the practitioner has exercised or has been deemed to have waived his right to a hearing as provided in Article VIII of these Bylaws.

(f) If, after the Executive Committee has considered the report and recommendation of the hearing committee and the hearing record, the Executive Committee's reconsidered recommendation is favorable to the practitioner, it shall be processed in accordance with subparagraph (d) of this Section 2. If such recommendation continues to be adverse, the Chief Executive Officer shall promptly so notify the practitioner, by certified mail, return receipt requested. The Chief Executive Officer shall also forward such recommendation and documentation to the Governing Body, but the Governing Body shall not take any action thereon until after the practitioner has exercised or has

been deemed to have waived his right to an appellate review as provided in Article VIII of these Bylaws.

(g) At its next regular meeting after receipt of a favorable recommendation, the Governing Body or its Executive Committee shall act on the matter. If the Governing Body's decision is adverse to the practitioner in respect to either appointment or clinical privileges, the Chief Executive Officer shall promptly notify him of such adverse decision by certified mail, return receipt requested, and such adverse decision shall be held in abeyance until the practitioner has exercised or has been deemed to have waived his rights under Article VIII of these Bylaws and until there has been compliance with subparagraph (i) of this Section 2. The fact that the adverse decision is held in abeyance shall not be deemed to confer privileges where none existed before.

(h) At its next regular meeting after all of the practitioner's rights under Article VIII have been exhausted or waived, the Governing Body or its duly authorized committee shall act on the matter. The Governing Body's decision shall be conclusive, except that the Governing Body may defer final determination by referring the matter back for further reconsideration. Any such referral back shall state the reasons therefor, shall set a time limit within which a subsequent recommendation to the Governing Body shall be made, and may include a directive that an additional hearing be conducted to clarify issues which are in question. At its next regular meeting after receipt of such subsequent recommendation, and new evidence in the matter, if any, the Governing Body shall make a decision either to provisionally appoint the practitioner to the staff or to reject him for staff membership. All decisions to appoint shall include a delineation of the clinical privileges which the practitioner may exercise.

(i) Whenever the Governing Body's decision will be contrary to the recommendation of the Medical-Dental Staff

Executive Committee, the Governing Body shall submit the matter to a Joint Conference Committee for further review and recommendation and shall consider such recommendation before making its decision final.

(j) When the Governing Body's decision is final, it shall send notice of such decision through the Chief Executive Officer to the Secretary of the Medical-Dental Staff, to the Chairman of the Executive Committee, and to the Director of the Division or Department concerned, and by certified mail, return receipt requested, to the practitioner.

Section 3. Reappointment Process.

* * * *

ARTICLE VI: CLINICAL PRIVILEGES

Section 1. Clinical Privileges Restricted.

* * * *

(d) Privileges granted to dentists shall be based on their training, experience, and demonstrated competence and judgment. The scope and extent of surgical procedures that each dentist may perform shall be specifically delineated and granted in the same manner as all other surgical privileges. Surgical procedures performed by dentists shall be under the overall supervision of the Director of the Division of Surgery. All dental patients shall receive the same basic medical appraisal as patients admitted to other surgical services. A physician member of the Medical-Dental Staff shall be responsible for the care of any medical problem of a dental patient that may be present at the time of admission or that may arise during hospitalization.

* * * *

ARTICLE VII: CORRECTIVE ACTION

Section 1. Procedure.

(a) Whenever the activities or professional conduct of any member of the Medical-Dental Staff are considered to

be lower than the standards or aims of the Medical-Dental Staff or to be disruptive to the operations of the Hospital, corrective action against such practitioner may be instituted by an officer of the Medical-Dental Staff, any Division or Department Director, any Section Chief, the Chief Executive Officer, or the Governing Body.

* * * *

ARTICLE VIII: HEARING AND APPELLATE REVIEW PROCEDURE

Section 1. Right to Hearing and to Appellate Review.

(a) When any practitioner receives notice of a recommendation of the Executive Committee that, if ratified by decision of the Governing Body, will adversely affect his appointment to or status as a member of the Medical-Dental Staff or his exercise of clinical privileges, he shall be entitled to a hearing before an ad hoc committee of the Medical-Dental Staff. If the recommendation of the Executive Committee following such hearing is still adverse to the affected practitioner, he shall then be entitled to an appellate review by the Governing Body before the Governing Body makes a final decision on the matter.

(b) When any practitioner receives notice of a decision by the Governing Body that will affect his appointment to or status as a member of the Medical-Dental Staff or his exercise of clinical privileges, and such decision is not based on a prior adverse recommendation by the Executive Committee of the Medical-Dental Staff with respect to which he was entitled to a hearing and appellate review, he shall be entitled to a hearing by the Governing Body before the Governing Body makes a final decision on the matter.

(c) All hearings and appellate reviews shall be in accordance with the procedural safeguards set forth in this Article VIII to assure that the affected practitioner is accorded all right to which he is entitled.

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Section 2. Request for Hearing.

(a) The Chief Executive Officer shall be responsible for giving prompt written notice of an adverse recommendation or decision to any affected practitioner who is entitled to a hearing or to an appellate review, by certified mail, return receipt requested.

(b) The failure of a practitioner to request a hearing to which he is entitled by these Bylaws within the time and in the manner herein provided shall be deemed a waiver of his right to such hearing and to any appellate review to which he might otherwise have been entitled on the matter. The failure of a practitioner to request an appellate review to which he is entitled by these Bylaws within the time and in the manner herein provided shall be deemed a waiver of his right to such appellate review on the matter.

(c) When the waived hearing or appellate review relates to an adverse recommendation of the Executive Committee or Governing Body, the same shall thereupon become and remain effective against the practitioner pending the Governing Body's final decision. The Chief Executive Officer shall promptly notify the affected practitioner of his status by certified mail, return receipt requested.

Section 3. Notice of Hearing.

(a) Within ten (10) days after receipt of a request for hearing from a practitioner entitled to the same, the Executive Committee or the Governing Body, whichever is appropriate, shall schedule and arrange for such a hearing and shall, through the Chief Executive Officer, notify the practitioner of the time, place, and date so scheduled, by certified mail, return receipt requested. The hearing date shall not be less than fifteen (15) days nor more than thirty (30) days from the date of receipt of the request for hearing; provided, however, that a hearing for a practitioner who is under suspension which is then in effect shall be

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held as soon as arrangements therefor may reasonably be made, but not later than twenty (20) days from the date of receipt of such practitioner's request for hearing.

(b) The notice of hearing shall state in concise language the act or omissions with which the practitioner is charged, a list of specific or representative charts being questioned, and/or the other reasons or subject matter that was considered in making the adverse recommendation or decision.

Section 4. Composition of Hearing Committee.

(a) When a hearing relates to an adverse recommendation of the Executive Committee, such hearing shall be conducted by an ad hoc hearing committee of not less than three (3) members of the Medical-Dental Staff appointed by the President of the Medical-Dental Staff in consultation with the Executive Committee, and one of the members so appointed shall be designated as Chairman. No staff member who has actively participated in the consideration of the adverse recommendation shall be appointed a member of this hearing committee.

Section 5. Conduct of Hearing.

(a) There shall be at least a majority of the members of the hearing committee present when the hearing takes place, and no members may vote by proxy.

* * * *

(f) Either a hearing officer, if one is appointed, or the chairman of the hearing committee or his designee, shall preside over the hearing to determine the order of procedure during the hearing, to assure that all participants in the hearing have a reasonable opportunity to present relevant oral and documentary evidence, and to maintain decorum.

(g) The hearing need not be conducted strictly according to rules of law relating to the examination of witnesses

or presentation of evidence. Any relevant matter upon which responsible persons customarily rely in the conduct of serious affairs shall be considered, regardless of the existence of any common law or statutory rule which might make evidence inadmissible over objection in civil or criminal action. The practitioner for whom the hearing is being held shall, prior to or during the hearing, be entitled to submit memoranda concerning any issue of procedure or of fact and such memoranda shall become a part of the hearing records.

(h) The Executive Committee, when its action has prompted the hearing, shall appoint one of its members, or some other Medical-Dental Staff member, to represent it at the hearing, to present the facts in support of its adverse recommendation, and to examine witnesses. The Governing Body, when its action has prompted the hearing, shall appoint one of its members to represent it at the hearing, to present the facts in support of its adverse decision, and to examine witnesses. It shall be the obligation of such representative to present appropriate evidence in support of the adverse recommendation or decision, but the affected practitioner shall thereafter be responsible for supporting his challenge to the adverse recommendation or decision by an appropriate showing that the charges or grounds involved lack any factual basis or any action based thereon is either arbitrary, unreasonable, or capricious.

(i) The affected practitioner shall have the following rights: to call and examine witnesses, to introduce written evidence, to cross-examine any witness on any matter relevant to the issue of the hearing, to challenge any witness, and to rebut any evidence. If the practitioner does not testify in his own behalf, he may be called and examined as if under cross-examination.

(j) The hearings provided for in these Bylaws are for the purpose of resolving, on an intra-professional basis,

matters bearing on professional competency and conduct. Accordingly, neither the affected practitioner nor the Executive Committee or Governing Body shall be represented at any phase of the hearing procedure by an attorney at law unless the hearing committee, in its direction, permits both sides to be represented by counsel. The foregoing shall not be deemed to deprive the practitioner, the Executive Committee, or Governing Body of the right to legal counsel in connection with preparation for the hearing or for a possible appeal; and if a hearing officer is utilized, he may be an attorney at law.

* * * *

(1) Within twenty (20) days after final adjournment of the hearing, the hearing committee shall make a written report and recommendation and shall forward the same, together with the hearing record and all other documentation, to the Executive Committee or to the Governing Body, whichever appointed it. The report may recommend confirmation, modification, or rejection of the original adverse recommendation of the Executive Committee or decision of the Governing Body. Thereafter, the procedure to be followed shall be as provided in Section 2 of Article V of these Bylaws.

Section 6. Appeal to the Governing Body.

(a) Within ten (10) days after receipt of a notice by an affected practitioner of an adverse recommendation or decision made or adhered to after a hearing as above provided, he may, by written notice to the Governing Body delivered through the Chief Executive Officer by certified mail, return receipt requested, request an appellate review by the Governing Body. Such notice may request that the appellate review be held only on the record on which the adverse recommendation or decision is based, as supported by the practitioner's written statement provided for below,

or may also request that oral argument be permitted as part of the appellate review.

(b) If such appellate review is not requested within ten (10) days, the affected practitioner shall be deemed to have waived his right to the same, and to have accepted such adverse recommendation or decision, and the same shall become effective immediately as provided in Section 2 of this Article VIII.

(c) Within ten (10) days after receipt of such notice of request for appellate review, the Governing Body shall schedule a date for such review, including a time and place for oral argument if such has been requested, and shall, through the Chief Executive Officer, by written notice sent by certified mail, return receipt requested, notify the affected practitioner of the same. The date of the appellate review shall not be less than ten (10) days nor more than thirty (30) days from the date of receipt of this notice of request for appellate review, except that when the practitioner requesting the review is under a suspension which is then in effect, such review shall be scheduled as soon as the arrangements for it may reasonably be made, but not more than twenty (20) days from the date of receipt of such notice.

(d) The appellate review shall be conducted by the Governing Body of not less than three (3) members.

(e) The affected practitioner shall have access to the report and record of the ad hoc hearing committee and all other material, favorable or unfavorable, that was considered in making the adverse recommendation or decision against him. He shall have twenty (20) days to submit a written statement in his own behalf, in which those factual and procedural matters with which he disagrees, and his reasons for such disagreement shall be specified. This written statement may cover any matters raised at any step in the procedure to which the appeal is related, and legal counsel may assist in its preparation. Such written state-

ments shall be submitted to the Governing Body through the Chief Executive Officer by certified mail, return receipt requested, at least twelve (12) days prior to the scheduled date of the appellate review. A similar statement may be submitted by the Executive Committee or hearing committee, and if submitted, the Chief Executive Officer shall provide a copy thereof to the practitioner at least six (6) days prior to the date of such appellate review by certified mail, return receipt requested.

(f) The Governing Body or review committee shall act as an appellate body. It shall review the record created in the proceeding, and shall consider the written statements submitted pursuant to Subparagraph (e) of this Section 6, for the purpose of determining whether the adverse recommendation or decision against the affected practitioner was justified and was not arbitrary or capricious. If oral argument is requested as part of the review procedure, the affected practitioner shall be present at such appellate review, shall be permitted to speak against the adverse recommendation or decision, and shall answer questions put to him by any member of the appellate review body. The Executive Committee or the Governing Body, whichever is appropriate, shall also be represented by an individual who shall be permitted to speak in favor of the adverse recommendation or decision and who shall answer questions put to him by any member of the appellate review body.

(g) New or additional matters not raised during the original hearing or in the hearing committee report, nor otherwise reflected in the record, shall be introduced at the appellate review only under unusual circumstances, and the Governing Body or the committee appointed to conduct the appellate review shall in its sole discretion determine whether such new matters shall be accepted.

(h) If the appellate review is conducted by the Governing Body, it may affirm, modify, or reverse its prior decision

or, in its discretion, refer the matter back to the Executive Committee for further review and recommendation within ten (10) days. Such referral may include a request that the Executive Committee of the Medical-Dental Staff arrange for a further hearing to resolve specified disputed issues.

(i) If the appellate review is conducted by a committee, such committee shall, within ten (10) days after the scheduled or adjourned date of the appellate review, either make a written report recommending that the Governing Body affirm, modify, or reverse its prior decision or refer the matter back to the Executive Committee for further review and recommendation within ten (10) days. Such referral may include a request that the Executive Committee arrange for a further hearing to resolve disputed issues. Within thirty (30) days after receipt of such recommendation after referral, the committee shall make its recommendation to the Governing Body as above provided.

(j) The appellate review shall not be deemed to be concluded until all of the procedural steps provided in this Section 6 have been completed or waived. Where permitted by the Hospital Bylaws, all action required of the Governing Body may be taken by a committee of the Governing Body duly authorized to act.

Section 7. Final Decision by Governing Body.

(a) Within fifteen (15) days after the conclusion of the appellate review, the Governing Body shall make its final decision in the matter and shall send notice thereof to the Executive Committee and, through the Chief Executive Officer, to the affected practitioner by certified mail, return receipt requested. If this decision is in accordance with the Executive Committee's last recommendation in the matter, it shall not be subject to further hearing or appellate review. If this decision is contrary to the Executive Committee's last recommendation, the Governing Body shall refer the matter to the Executive Committee

for further review and recommendation within thirty (30) days, and shall include in such notice of its decision a statement that a final decision will not be made until the Committee's recommendation has been received. At its next meeting after receipt of the Executive Committee's recommendation, the Governing Body shall make its final decision with like effect and notice as first above provided in this Section 7.

(b) Notwithstanding any other provision of these Bylaws, no practitioner shall be entitled as a right to more than one hearing and one appellate review on any matter which shall have been the subject of action by the Executive Committee or by the Governing Body, or by both.

ARTICLE IX: OFFICERS

* * * *

Section 6. Duties of Officers.

(a) President: The President shall serve as the Chief of Staff of the Medical-Dental Staff to:

* * * *

(5) Be responsible for the enforcement of Medical-Dental Staff Bylaws. . . .

* * * *

ARTICLE X: DIVISIONS AND DEPARTMENTS

* * * *

ARTICLE XI: COMMITTEES

Section 1. Executive Committee.

(a) The Executive Committee shall consist of the President, 1st Vice President, 2nd Vice President, Past President, the Secretary of the Medical-Dental Staff, and a member elected from each of the subsequent Divisions:

Medicine, Surgery, Obstetrics-Gynecology, Pediatrics, Family Practice, and two members from the combined Departments of Pathology, Radiology, Anesthesiology, and Emergency Medicine. The Directors of Divisions and Departments may serve on the Executive Committee if elected to do so by their respective Divisions. The members of the Divisions and Departments will serve for a period of two consecutive years and may be reappointed by the Division or Department. The members from the Divisions of Medicine, Surgery, and Obstetrics-Gynecology are to be elected on even years and the members from the Divisions of Family Practice and Pediatrics will be elected on odd years. Due to the combination of the Departments of Radiology, Pathology, Anesthesiology and Emergency Medicine, a member shall be elected each year to serve for a period of two years.

The Secretary of the Staff shall serve as Secretary of the Executive Committee. The President shall serve as Chairman.

(b) The duties of the Executive Committee shall be:

* * * *

(7) To make recommendations on Hospital management matters to the Governing Body through the Chief Executive Officer;

(8) To fulfill the Medical-Dental Staff's accountability to the Governing Body for the medical care rendered to patients in the Hospital;

(11) To review the credentials of all applicants and to make recommendations for staff membership, assignments to departments, and delineation of clinical privileges;

* * * *

Section 2. Credentials Committee.

(a) Composition: The Credentials Committee shall consist of the President of the Medical-Dental Staff as Chairman, Past President, First Vice President, the Directors of the Divisions, the Section Chiefs, and one member each from the Departments of Radiology, Pathology, Anesthesiology, Rehabilitation Medicine, Emergency Medicine, and the Director of Medical Education.

The First Vice President shall serve as Secretary transmitting the proceedings of the Committee to the Executive Committee. This Committee shall meet once a year or at the call of the President of the Medical-Dental Staff or his substitute. A member of the Administrative Staff of the Hospital shall be present in an ex-officio capacity and excused if an Executive Session is called.

(b) Duties: The duties of the Credentials Committee shall be:

(1) To review the Credentials of all applicants and to make recommendations for membership and delineation of clinical privileges in compliance with Articles V and VI of these Bylaws, taking into account mental and physical competence, experience, training, certifications, memberships in professional societies, and all other pertinent matters;

(2) To make a report to the Executive Committee on each applicant for Medical-Dental Staff membership or clinical privileges, including specific consideration of the recommendations from the Divisions, Departments, and Sections in which such applicant requests privileges;

* * * *

ARTICLE XII: MEDICAL STAFF MEETINGS

* * * *

ARTICLE XIII: COMMITTEE, DIVISION, DEPARTMENT, AND SECTION MEETINGS.

* * * *

ARTICLE XIV: IMMUNITY FROM LIABILITY

* * * *

ARTICLE XV: RULES AND REGULATIONS

* * * *

ARTICLE XVI: AMENDMENTS

These Bylaws may be amended after notice of the proposed amendment at any regular or special meeting of the Medical-Dental Staff. A proposed amendment shall be referred to a special committee which shall report on it at the next regular meeting of the Medical-Dental Staff or at a special meeting called for such purpose. In no event shall the time between the notice and the vote on a proposed amendment be less than three (3) days. To be adopted, an amendment shall require a majority vote of the Active Medical-Dental Staff present. Amendments so made shall be effective when approved by the Governing Body.

ARTICLE XVII: ROBERT'S RULES OF ORDERS

* * * *

RULES AND REGULATIONS
OF
MEDICAL-DENTAL STAFF
OF
FORSYTH MEMORIAL HOSPITAL

A. ADMISSION AND DISCHARGE OF PATIENTS.

1. A patient may be admitted to the Hospital only by a member of the Medical-Dental Staff.

* * * *

IN WITNESS WHEREOF, these Bylaws, Rules and Regulations re adopted by the Medical-Dental Staff of Forsyth Memorial Hospital, shall replace all previous Bylaws, Rules and Regulations, and become effective upon approval by the Governing Body of the Hospital.

ADOPTED by the active Medical-Dental Staff on January 20, 1976.

/s/ Illegible
President of the Staff

/s/ FREDERICK B. WEAVER M.D.
Frederick B. Weaver, M.D.
Secretary of the Staff

APPROVED by the Governing Body on February 10, 1976.

/s/ DEBORAH D. LANTERN
Deborah D. Lantern
Secretary of the Governing Body

APPENDIX E

AMERICAN MEDICAL ASSOCIATION

535 NORTH DEARBORN STREET • CHICAGO ILLINOIS 60610 • PHONE (312) 751,6000 • TWX 910-221-0300

February 25, 1977

Seward P. Nyman, D.P.M.
Executive Director
American Podiatry Association
Chevy Chase Circle, Northwest
Washington, D. C. 20015

Dear Doctor Nyman:

I am responding to your letter of February 9 and your inquiry about the status of the statement on podiatry that originated within the AMA-APA Liaison Committee on Podiatry.

As you know, the Liaison Committee statement affirmed that podiatrists should be granted practice privileges in hospitals within the scope of their individual competence. The complete statement, which is attached, was adopted by our Board of Trustees in October, 1976.

The matter of practice privileges for podiatrists was also before our House of Delegates for decision in Philadelphia at the time of our 1976 Clinical Convention in December. Report C of the Council on Medical Service responded to Resolution 20, which was introduced at our 1976 Annual Convention, and a Substitute Resolution that was also considered. The Report makes reference to the content of both the original and the Substitute Resolution. The exact working of the Substitute Resolution is as follows:

> "Resolved, That the AMA House of Delegates request the JCAH to continue its present policy regarding medical staff membership as expressed in its Accreditation Manual for Hospitals."

Following discussion, the House voted in Philadelphia to adopt Report C of the Council on Medical Service and Substitute Resolution 20 (A-76). The actions "support the extension of practice privileges in hospitals to qualified, licensed podiatrists in accordance with their training, experience, and demonstrated competence and judgment, which is the same principle as included in the statement emanating from the Liaison Committee."

Please let me know if I can provide any additional information.

Sincerely,

/s/ James H. Sammons
James H. Sammons, M. D.

JHS/nn
Attachment
cc: Robert B. Hunter, M. D.

STATEMENT ON PODIATRY, approved by Board of Trustees, October 1976

The AMA-APA Liaison Committee goes on record "as recommending as a position of the sponsoring organizations of the JCAH that podiatrists as a professional group should not be denied practice privileges in hospitals (which is consistent with the JCAH glossary of privileges) and that it is appropriate that qualified podiatrists may be granted practice privileges within the scope of individual competence."

The AMA-APA Liaison Committee is committed to the identification and development of guidelines for aiding medical staffs in assessing the competence of podiatrists applying for hospital privileges.

APPENDIX F

STATEMENT ON HOSPITAL PRIVILEGES FOR PODIATRISTS BY THE JOINT COMMISSION ON ACCREDITATION OF HOSPITALS

Podiatrists who are appropriately licensed may be granted clinical privileges that are based on their documented training, experience, and current competence. When podiatrists are granted privileges, they should be bound by the applicable medical staff bylaws, rules and regulations, which should contain specific references to podiatric services. The conditions under which a podiatrist, with the concurrence of a physician member of the medical staff, may initiate admission or discharge of a patient and may, within the limits of his licensure, write orders and prescribe medications, should be defined in the medical staff bylaws, rules and regulations. The bylaws should provide that any surgical privileges granted to podiatrists be exercised under the overall supervision of the chief of surgery, or the physician chairman or designated physician member of a medical staff operating room committee.

Reprinted from *JCAH Monograph Medical Staff Bylaws*, 1978.

APPENDIX G

NORTH CAROLINA HOSPITAL ASSOCIATION
POST OFFICE BOX 10937
TELEPHONE (919) 834-8434
RALEIGH, NORTH CAROLINA 27605

MEMO TO: Chief Executive Officers of Member Institutions

FROM: Marion J. Foster, President
W. C. Harris, Jr., Association Attorney
DATE: February 1, 1980
SUBJECT: Hospital Bylaws

We suggest that all hospitals establish a process in their hospital bylaws for considering applications for clinical privileges from licensed podiatrists.

In your Medical Staff Bylaws, Rules and Regulations, you should include the following:

(1) Suggested definition of Podiatrist—A podiatrist is a graduate of a school of podiatry approved by the Council on Education of the American Podiatry Association and licensed to practice podiatry in North Carolina.

(2) Whenever "physicians, osteopaths and dentists" are grouped add "podiatrist".

(3) Require podiatrist to abide by Code of American Podiatry Association.

(4) State privileges granted a podiatrist shall be based on his training, experience and current demonstrated competence and judgement.

(5) Provide that the scope and extent of surgical procedures each podiatrist may perform shall be specifically defined and granted in the same manner as all other surgical privileges.

(6) Podiatric patients shall receive the same basic medical appraisal as patients admitted to other surgical ser-

vices; and a physician member of the Medical Staff shall be responsible for the care of any medical problem that may be present at the time of admission or that may arise during hospitalization for podiatric patients.

(7) A podiatrist with clinical privileges may, with the concurrence of an appropriate member of the Medical Staff, initiate the procedure for admitting a patient. The responsibility shall be a dual responsibility for the overall aspects of the patient's care throughout the hospital stay including medical history and physical examination. Patients admitted for podiatric care shall be given the same basic medical appraisal as patients admitted for other services.

(8) Under Podiatric Surgery—a patient admitted for podiatric care is a dual responsibility involving the podiatrist and physician member of the Medical Staff. Podiatric surgery shall be under the overall supervision of Chief of Surgery or his designee.

(a) Podiatrist shall prepare podiatric history justifying hospital admission, a description of the examination of the feet, and a pre-operative diagnosis; an operative report with findings and technique; a statement of any tissue removed; send tissue specimens and foreign bodies to hospital pathologist; and progress notes, conditions on discharge and follow-up plant.

(b) Physician member shall prepare admission history and physical examination prior to anesthesia and surgery; be available for general medical care, and prepare discharge summary.

(c) A podiatrist with clinical privileges may, with the concurrence of an appropriate member of the Medical Staff, initiate the procedure for discharging a patient.

APPENDIX H

Department of Health and Human Services
HEALTH CARE FINANCING ADMINISTRATION
1849 GWYNN OAK AVENUE
Baltimore, Maryland 21207

REFER TO

Health Standards and Quality Bureau
Office of Standards and Certification

Mr. Donald L. Parrot
Director of Interprofessional Affairs
American Podiatry Association
20 Chevy Chase Circle, N.W.
Washington, D. C. 20015

Dear Mr. Parrot:

This is in response to your recent letter requesting clarification of current statutory and regulatory requirements concerning the obligation of Medicare and Medicaid participating hospitals to consider applications from podiatrists for clinical privileges.

Title XVIII of the Social Security Act includes doctors of podiatry in its definition of a physician, but limits the podiatrist responsibilities "to functions which he is legally authorized to perform as such by the State in which he performs them." The regulatory provision addressing the functions a State authorizes podiatrists to perform is embodied in the Medicare hospital requirements 42 CFR 405.1020—State and Local Laws. In addition there are two areas of the regulations that apply to physicians' staff appointments. These requirements are included in 42 CFR 405.1021(e)—Governing Body and 42 CFR 405.1023(d) and (e)—Medical Staff. The provisions provide that qualified applicants may not be denied clinical privileges on the basis of racial discrimination, other Civil Rights violations, or because of an applicant's membership in a specialty body or society. Section 405.1023(e)(4) also states that "all qualified candidates are considered by the credentials com-

mittee." These requirements are designed to assure that a hospital has acceptable written policies and procedures governing staff qualifications, selection criteria, and appeal mechanisms. Accordingly, all persons qualified by education and training must be considered for hospital staff privileges, should they apply. A hospital that has policies or selection criteria which excludes podiatrists from consideration would not be in compliance with Medicare requirements.

Section 1861 of the Social Security Act, however, states "Nothing in this title shall be construed to authorize any Federal officer or employee to exercise any supervision or control over the practice of medicine or the manner in which medical services are provided, or over the selection, tenure, or compensation of any officer or employee of any institution, agency, or person providing health services; or to exercise any supervision or control over the administration or operation of any such institution, agency, or person."

Given the above, the Health Care Financing Administration does not have the authority to intervene in cases of individual physician grievances. We do, however, have authority to investigate complaints that hospitals are not complying with the Conditions of Participation (i.e., the requirements referenced above).

With regard to the proposed revision of the Conditions of Participation for Hospitals, you can be assured your comments will be considered in the development of final rule.

We appreciate your interest in this matter.

Sincerely yours,

/s/ JANET M. HARRYMAN
Janet M. Harryman
Director
Division of Hospital Services

APPENDIX I

IN THE UNITED STATES DISTRICT COURT FOR THE MIDDLE DISTRICT OF NORTH CAROLINA WINSTON-SALEM DIVISION

Civil Action No. C-83-75-WS

CARLOS T. COOPER, JR., D.P.M., *et al.*
Plaintiffs,

vs.

FORSYTH COUNTY HOSPITAL AUTHORITY, INC. *et al.*
Defendants,

AFFIDAVIT OF J. FINLEY LEE, Ph.D.

I, J. Finley Lee, Ph.D., being first duly sworn, deposes and says:

I.

"My name is J. Finley Lee and I live at 614 Croom Court in Chapel Hill, North Carolina where I am the Julian Price Professor of Business Administration at the University of North Carolina. I hold a bachelors degree in economics from Davidson College in 1961, a masters degree from the University of Florida in 1962, also in economics, and a doctorate in applied economics from the University of Pennsylvania which I attained in 1965. Upon obtaining my doctorate I spent two years in the United States Army stationed at the Naval Academy in Annapolis, thereafter went into business for a short period of time in Philadelphia, Pennsylvania, and was appointed an as-

sociate professor at Florida State University until 1970 when I came to the University of North Carolina at Chapel Hill and have remained there since 1970. My chair is in the School of Business Administration. I am the author of approximately fifty or sixty articles and books, principally in the area of applied economics, data management, generally working with statistics. I have been qualified as an expert in the fields of economics and statistics and testified in the Superior Courts of Mecklenburg County, Buncombe County, New Hanover County, Guilford County, Carteret County, and Forsyth County. I have also qualified as an expert and testified in the Eastern, Middle and Western District Federal Courts of North Carolina, as well as the United States Tax Court.

II.

I have examined the relevant appendices to the brief on summary judgment, answers to interrogatories propounded by plaintiffs to the defendant Hospital and to the defendant individual orthopedic surgeons, have conducted interviews with the plaintiffs, have independently investigated the factual background of this case to an extent adequate in my professional judgment to form an opinion based on reasonable and established economic principles.

III.

In my opinion, the 'product market' which forms the basis of competition between plaintiffs and defendant orthopedic surgeons consists of the 'rendering of in-patient foot surgery services which both orthopedic surgeons and podiatrists are authorized by state law to perform'. The basis for my opinion rests upon the fact that, of all foot surgery procedures which both podiatrists and orthopedic surgeons are currently licensed to perform, orthopedic surgeons have performed 94 percent of all such procedures performed at defendant Hospital (Exhibit 1, defendant

Hospital's answers to plaintiffs' first act of interrogatories, answer to question no. 3). Moreover, of those foot surgery procedures which podiatrists are not licensed to perform, orthopedic surgeons have performed only 17 percent of all such procedures performed at defendant Hospital. Therefore, it appears that the product market which forms the basis of competition for the rendering of foot surgery services that podiatrists are authorized to perform is limited essentially to the competition between podiatrists and orthopedic surgeons, since only 6 percent of these procedures are presently being performed by other specialists. In my field, a 94 percent share of market is extremely rare and constitutes an essential and classical monopoly. The foregoing conclusion accords with the generally accepted economic definition of the relevant product market which is defined as 'the relevant set of goods or services in which the products or services offered by the defendants compete'.

IV.

In my opinion, the 'geographic market' which forms the boundaries of competition between plaintiffs and defendant orthopedic surgeons consists of the Forsyth County community. The basis for my opinion rests upon the fact that, of all patients that have been treated at defendant Hospital, approximately 68 percent of these patients reside in Forsyth County (exhibit 1, defendant Hospital's answers to plaintiffs' first set of interrogatories, answers to questions 11-16). Moreover, of all patients that have been treated with in-patient foot surgery procedures by defendant orthopedic surgeons, approximately 70 percent of these patients reside in Forsyth County (defendant orthopods' supplemental answers to plaintiffs' first set of interrogatories). Of the remaining patients treated by defendant Hospital and defendant orthopedic surgeons who did not reside in Forsyth County, the remaining 99 coun-

ties of North Carolina contributed approximately 30 percent of these patients.

In my field, a market is clearly circumscribed by a 70 percent patronage. This is especially the case when the remaining patrons come from a widely disbursed area (exhibit 17, defendant Hospital's response to plaintiffs' third set of interrogatories, answer to question no. 1; defendant orthopods' answers to plaintiff's first set of interrogatories). It appears that the geographic market in which plaintiffs and defendants compete for the provision of in-patient foot surgery is limited to the Forsyth County community in which defendant Hospital, an acute, public hospital, maintains its place of business. In conclusion, based on the data which illustrate a significant degree of market concentration and the generally accepted perception that Forsyth Memorial Hospital is the primary surveyor [sic] of medical care for the Forsyth County community, the inescapable conclusion is that the county is the relevant geographic market. The foregoing analysis is in accord with the generally accepted economic definition of the geographic market, which is defined as 'the geographic area of effective competition in which the relevant products or services are traded.'

V.

In my opinion, and based upon the evidence supplied by defendant Hospital and defendant orthopedic surgeons, orthopedic surgeons possess a clear and ongoing significant monopoly power relevant to in-patient foot surgery in the Forsyth County community (see paragraph 3 above), in that orthopedic surgeons presently perform 94 percent of all foot surgery procedures which both orthopedic surgeons and podiatrists are licensed to perform. The foregoing analysis is in accord with the generally accepted economic specification of monopoly power which is defined as 'the power to control prices or exclude competition.'

VI.

In my opinion, defendant Forsyth Hospital possesses a de facto monopoly over the granting/denial of admitting privileges to practitioners in the Forsyth County community. Inasmuch as Baptist Hospital, by virtue of its teaching hospital status, cannot grant admitting privileges to only those practitioners who are not faculty members of Bowman Gray School of Medicine; and, inasmuch as Medical Park Hospital, by virtue of its status as a privately owned hospital, grants admitting privileges to only those practitioners who possess proprietary interests in that hospital (appendix exhibit 2), defendant Forsyth Hospital is the only hospital in the Forsyth County community to which independent practitioners may apply for admitting privileges. Therefore, defendant Forsyth Hospital possesses a de facto monopoly over the granting/denial of admitting privileges to practitioners in the Forsyth County community.

Further this affiant saith not."

This the 20 day of August, 1984.

/s/ J. FINLEY LEE
J. Finley Lee, Ph.D.

Sworn to and subscribed before me
this 20th day of August, 1984.
/s/ NANCY E. WALLACE
Nancy E. Wallace
Notary Public
My Commission Expires: 2/12/89

APPENDIX J

Excerpts of Transcript of By Laws Committee Meeting on June 26, 1980

Page 32, lines 7-25

MR. SIZEMORE: Dr. Pollock, have you had the opportunity to observe a podiatrist, any podiatrist, performing surgery?

DR. POLLOCK: In his office?

MR. SIZEMORE: Anywhere, sir.

DR. POLLOCK: No, sir, I have not.

MR. SIZEMORE: Neither in the hospital nor in an office. Is that correct?

DR. POLLOCK: No, sir. That's correct.

MR. SIZEMORE: Have you ever practiced in a hospital where podiatrists had clinical privileges or were practicing?

DR. POLLOCK: No, sir.

MR. SIZEMORE: Okay, sir. So is it fair to say, that you have no direct experience with podiatry or podiatrists?

DR. POLLOCK: That's not fair to say.

MR. SIZEMORE: It's not? Could you state why it's not?

Page 33, lines 1-25

DR. POLLOCK: If you'd like me to elaborate, I'd be glad to. I've seen many of the complications of podiatrist—podiatric surgery in this town and from other areas.

MR. SIZEMORE: When you say complications, sir, what do you mean?

DR. POLLOCK: Well, what do you ordinarily mean when you say complications?

MR. SIZEMORE: Bad results.

MR. SIZEMORE: But you're a medical man, and so what do you mean? You mean bad results, is that—

DR. POLLOCK:—Bad results or—or poor results of previously-done foot surgery.

MR. SIZEMORE: Could you describe what those results were?

DR. POLLOCK: I don't believe that I will answer that question, because these were private patients and I don't care to disclose the information about them.

MR. SIZEMORE: Well, I'm not asking for the names of patients, Doctor, I'm just asking for a description of the results.

DR. POLLOCK: I'm sorry. I don't see the relevancy of that and I must refuse at this time to answer that question.

Page 35, lines 10-25

MR. SIZEMORE: Okay, sir. Have you formed any conclusions about whether the by-laws should be amended to provide for podiatry?

DR. POLLOCK: Have I formed any conclusions? Yes, certainly I have.

MR. SIZEMORE: And what is your opinion, sir?

DR. POLLOCK: My personal opinion is that they should not.

MR. SIZEMORE: They should not. And could you state the basis for that opinion?

DR. POLLOCK: Well, you know, I believe that that basis is fairly apparent, from the line of questioning that—that occurred the last time. I think that you're trying to compare an education that these men have with a university education that M.D.'s have, that is

Page 36, lines 1-25

more—that is longer in years, that is more comprehensive, that deals with the wholestic approach to the human body, that is just a better way of doing business, in my opinion.

MR. SIZEMORE: A better way of doing medical business? Is that—I mean, is that what you mean by doing business?

DR. POLLOCK: That is correct.

MR. SIZEMORE: And how does that relate to whether or not a practitioner should be permitted to treat patients in the hospital?

DR. POLLOCK: Practitioner of what? An M.D.?

MR. SIZEMORE: A podiatrist or an M.D. that's qualified, yes.

DR. POLLOCK: Well, we set standards for the quality of medical care, as you well know. The Joint Commission, the AMA, various organizations, and even now the federal government set standards for the quality of medical care. And those standards are fairly apparent in this community, they have always, for the past several years, been quite apparent. We have not previously had podiatric surgeons or podiatrists on the staff of this hospital. Their training has changed somewhat in the last several years, I understand. But it's still inferior training, in my opinion, when compared with that of an M.D.

Page 37, lines 1-10

MR. SIZEMORE: Of any M.D.?

DR. POLLOCK: Of any M.D., and especially one who has had surgical training and who has passed the qualifications of his boards.

MR. SIZEMORE: So would it be fair to say that, in your opinion, someone who is not an M.D. and is not

trained in a medical institution should not be permitted to perform surgery in a hospital. Is that a fair statement?

DR. POLLOCK: Yes, that's a fair statement.

Page 78, lines 3-25

MR. HORTON: All right, sir. Now when we talked last, I think it was about two weeks ago, Dr. Early, you cited the Seldon Report which, I believe, was published in 1961, and you had a copy of it. Is that correct, sir?

DR. EARLY: I have one.

MR. HORTON: Yes, sir. And that Seldon Report, I believe it came out in the testimony, had been prepared by the American Podiatry Association and was a report of the status of the podiatric education at that time. Is that correct?

DR. EARLY: That is—that was my understanding.

MR. HORTON: Yes, sir. Now, since that time have you become familiar with the status of the podiatric education today?

DR. EARLY: Well, that—the problem that I referred to to begin with; how to evaluate podiatric education? Now it's possible that if I took a year and somebody subsidized me and I went around to all the schools, maybe I could refer—could evaluate it. But that is our problem in evaluating podiatric education, in my opinion.

MR. HORTON: Yes, sir. I gather, Dr. Early, it's your desire to be fair in this thing. It's just

Page 79, lines 1-14

that it's very difficult moving from a different frame of reference to evaluate another system of education.

DR. EARLY: That is correct.

MR. HORTON: And you realize, of course, Dr. Early, that these gentlemen here who are seeking hospital privileges have gone to a great deal of trouble and expense, and I'm sure that, although you may not agree with them, you sympathize with their efforts to do this.

DR. EARLY: I understand.

MR. HORTON: Yes, sir. And Dr. Early, one of your problems, then, is that you just aren't as familiar as you'd like to be with the status of podiatric education today?

DR. EARLY: That is correct.

Page 80, lines 11-24

MR. HORTON: Doctor, I realize that you have a great many time pressures, but I would like to ask you just one or two questions. Have you ever had occasion to visit a podiatric school at any time?

DR. EARLY: No.

MR. HORTON: Have you ever had occasion to visit a podiatric clinic, or perhaps even an office of a practicing podiatrist?

DR. EARLY: No.

MR. HORTON: Have you had occasion to talk with podiatrists about their training and about what they would like to do?

DR. EARLY: No, I wouldn't say—I don't believe I have.

Excerpts of Transcripts of Bylaws Committee Meeting July 9, 1980

Page 74, lines 2-14

MR. HORTON: I gather from what you said before, Dr. Kooken, that if it could be shown that podiatrists could perform procedures better than perhaps some other type of practitioner, you would have no objection to their being

admitted to the staff so long as they followed all the procedures and qualified in every respect? Am I right?

DR. KOOKEN: No, I don't think that's right.

MR. HORTON: All right, sir. Now what would be your objection?

DR. KOOKEN: Philosophically, I'm opposed to that.

Page 76, lines 12-21

MR. HORTON: And the basis of this philosophy is that you just simply don't think that they should be permitted to admit people to the hospital?

DR. KOOKEN: Yes.

MR. HORTON: No matter how serious the patient—

DR. KOOKEN:—If the patient is that serious, I think they need to be taken care of by a doctor. That's what—that's my feeling. You're not going to change it, no matter how long you talk.

Page 89, lines 3-22

DR. UNDERDAL: Shortly after Dr. Johnson came here, he met me in the front lobby of this hospital and presented me with his credentials. I reviewed them very briefly and very quickly at that time. I—but I don't recall any of that information at all, you know, at this time.

MR. SIZEMORE: Did you discuss his application with him at that time?

DR. UNDERDAL: I probably did, I don't recall.

MR. SIZEMORE: Do you recall whether you were opposed or unequivocal or—

DR. UNDERDAL:—Oh, I'm sure—I'm sure I was opposed.

MR. SIZEMORE: You're sure you were opposed to his application?

DR. UNDERDAL: I'm sure I was opposed, yes, sir. You asked at that time.

MR. SIZEMORE: Yes, sir. How about today?

DR. UNDERDAL: I still am.

Page 94, lines 8-25

MR. SIZEMORE: You've been opposed to everything about podiatry?

DR. UNDERDAL: Yes, sir, up to this point, I have. And I've heard nothing in all of the discussions here that has changed my mind. I'm open here, I've sat, I've listened and I haven't been changed. So yes, I'm generally opposed.

MR. SIZEMORE: Well, what would change your mind, Dr. Underdal?

DR. UNDERDAL: I think one thing that would change my mind, if I knew more about podiatry. And I'm not talking about podiatrists. And I don't think this committee alludes itself to podiatrists. And I've—that's one thing that's been bothering me, is that before we can talk about podiatrists on this staff, we have to talk about podiatry. And we have not alluded much to that. Because that's the only thing that this by-laws committee can address itself to, is the field of podiatry. Because we are

Page 95, lines 1-10

not talking about a person at this meeting. We are talking about the field of podiatry. We have to leave the individual out of it, because we are talking in a by-laws sense about all podiatrists who apply today and all of the future. So I think the individual part of this is wrong. And I don't know enough about podiatry. I've heard it, but I have not been in any of my training—in any of my exposure, I

haven't had any exposure to it. I am opposed because I am not knowledgeable about it and I haven't seen any point to become knowledgeable about it.

Page 95, lines 13-25

MR. SIZEMORE: So that, in your own statement, your opposition is base on ignorance—

DR. UNDERDAL:—Absolutely—

MR. SIZEMORE:—Of the field of podiatry.

DR. UNDERDAL: Absolutely.

MR. SIZEMORE: And you would propose that you, sir, would conduct a review of podiatry. Would you be willing to take the time to—

DR. UNDERDAL:—No, sir, I would not. I—I do not have personal interest whatsoever. If I was directed to, due to my position, I probably would have to consider it. But no, sir, I wouldn't do it personally.

Page 161, lines 8-25

DR. EARLY: I understand this part is for brief, summarizing statements. And we—as I understand it, we have been trying to evaluate podiatrists, including podiatric education and, of course, I know that you can't do this in a matter of hours, even the number of hours we've spent on it, plus some.

But basically, as some of the other speakers have spoken to, we feel that podiatric education may be suspect. We feel that a physician ought to be a total physician to begin with, and then subspecialized in some specialty, if he so chooses, and in particular in the surgical field. And also, as I stated in my first closing statement at the first meeting, I—speaking from the point of view of the hospital, I still feel that the hospital has a lot of well qualified physicians that can do any of the procedures that may need

to be done on the foot. And from the standpoint of the hospital, I don't see that we need another group of practitioners to do this type of procedure.

Page 162, lines 1-21

And I think that our M.D. specialists in orthopedic surgery and plastic surgery are better trained and better qualified to do these procedures than the podiatrists, from what I've gotten from these proceedings and from the other information, including the total record over there.

Also, I would want to bring in just briefly the fact that the occupancy rate, bed occupancy rate at this hospital is very high, has been tight. We have eight hundred and—no seven hundred and eighty-one beds, including bassinets, but we have four hundred and ten, and we have more than that now, of physicians and dentists who are on the staff. As we pointed out before, the general dentists don't really admit patients.

And I just wanted to put in the record that the occupancy rate—to back up what I said about the occupancy rate, the occupancy rate on medicine on weekends in the three months from January to March was 94.8 percent on the weekends, and on the weekdays it was 98 percent. And on surgery it was 89.4 percent on the weekends, and 97 percent during the weekdays. So that's really about all I have to say at this point.

APPENDIX K

REPORT OF BYLAWS COMMITTEE AUGUST 5, 1980

Your Bylaws Committee, consisting of Chairman Dr. George Podgorny and members Dr. Robert Means and Dr. Jeff Helms, was requested by the President of the Forsyth Memorial Hospital Medical-Dental Staff to consider and make recommendation to the Executive Committee, as to whether the Medical-Dental Staff Bylaws should be amended so as to permit podiatrists to have admitting and surgical privileges at Forsyth Memorial Hospital.

Pursuant to the request of the President of the Medical-Dental Staff, your Committee, following due notice to all interested parties (including three applicants for admitting and surgical privileges and their attorneys), held public hearings on this question on June 3, 1980, June 26, 1980, and July 9, 1980. These hearings lasted for several hours and all parties desiring to be heard, or to ask questions, were given an opportunity to do so. A transcript of these proceedings has been prepared and is available in the office of Miss Emma Lou Noell. All members of the Medical-Dental Staff are encouraged to read this transcript.

In addition to the transcript of the proceedings, a large number of exhibits have been presented to the Committee, reviewed by the Committee, and are on file in the office of Miss Emma Lou Noell. Again, all members of the Medical-Dental Staff are encouraged to review these exhibits.

Your Committee has spent many hours conducting the hearings and reviewing the exhibits in an effort to make an objective determination, based upon the evidence presented, as to whether or not it is in the best interest of quality patient care at Forsyth Memorial Hospital for podiatrists to have admitting and surgical privileges. The present Bylaws of the Medical-Dental Staff of Forsyth Memorial Hospital do not permit podiatrists to have ad-

mitting or surgical privileges. The present Bylaws do permit podiatrists to have privileges as allied health personnel, and thus to perform non-surgical procedures for patients at Forsyth Memorial Hospital upon the order of, and under the supervision of, a member of the Medical-Dental Staff.

The first purpose of the Medical-Dental Staff of Forsyth Memorial Hospital, as stated in Article II of its Bylaws, is "To insure that all patients admitted to or treated in any of the facilities, departments, or services of the hospital shall receive the best possible care". Your Committee concludes that an amendment to the Bylaws of the Medical-Dental Staff so as to permit podiatrists to have admitting and surgical privileges would be inconsistent with this statement of the purpose of the organization, and thus your Committee recommends that the Bylaws not be changed so as to allow podiatrists to have such privileges.

It would be impractical to attempt in this report to set out all of the evidence and facts that causes your Committee to reach this conclusion. The primary basis for our recommendations, fully supported by the testimony and exhibits offered and considered by the Committee, is the fact that Forsyth Memorial Hospital has several orthopedic surgeons on its staff, all of the functions performed by a podiatrist may be performed by an orthopedic surgeon, and podiatrists do not receive a medical education or training equivalent to that received by orthopedic surgeons:[1] Thus, orthopedic surgeons as a group can better serve the

[1] By way of illustration only: The evidence before the Committee indicates that graduate training is available in five schools of podiatry. The graduate podiatric training does not lend itself readily to scrutiny and comparison, such critical aspects as teaching laboratories, library and support facilities do not appear to measure up to those of medical and dental schools. Schools of podiatry are free-standing and without university base or university association. The faculties of the podiatric schools are primarily podiatrists, with some medical doctors, but the M.D.'s are usually referred to as "Adjunct Professors" which we assumed to be visiting professors.

needs of the whole patient by diagnosing and treating physical and emotional causes which manifest themselves in terms of foot disorders. The training of a podiatrist differs from that of orthopedic surgeons in that podiatrists do not receive internship and residency training equivalent to that of an orthopedic surgeon:[2] In fact, the evidence before your Committee indicates that even an orthopedic surgeon, who if he possesses no more internship and residency training than that received by podiatrists, would not be permitted to have surgical privileges at Forsyth Memorial Hospital.

In summary, your Committee recommends that the present Bylaws which allow podiatrists to have privileges as allied health personnel be retained, and that the provisions of the Bylaws which restrict admitting and surgical privileges to duly qualified physicians and dentists remain unchanged.

Respectfully submitted this 5th day of August, 1980.

BYLAWS COMMITTEE OF MEDICAL-DENTAL STAFF
OF FORSYTH MEMORIAL HOSPITAL

/s/ GEORGE PODGORNY, M.D.
Chairman

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[2] By way of illustration only: Podiatry residency training programs are single programs in hospitals with no other medical or surgical residencies, contrary to the medical residency programs which are usually multidisciplinary with medical school affiliations. Put another way, most podiatric postgraduate training programs are in hospitals that lack residency programs in traditional medical specialties, thus providing no cross-current of education and information. Further, the postgraduate training of podiatrists consists of one or two year residency programs, as compared to at least four years training for medical-surgical specialties.

/s/ JEFF R. HELMS, M.D.
Member

/s/ ROBERT L. MEANS, M.D.
Member

APPENDIX L

Excerpts of Transcript of Board of Trustees

Meeting September 9, 1980

Page 4, lines 4-25

Dr. Montgomery: The first purpose of the medical-dental staff of Forsyth Memorial Hospital, as stated in Article Two of its bylaws is to ensure that all patients admitted to or treated in any of the facilities, departments or services of the hospital shall receive the best possible care.

Your committee [the bylaws committee] concludes that an amendment to the bylaws of the medical-dental staff, so as to permit podiatrists to have co-admitting and surgical privileges would be inconsistent with this statement of the purpose of the organization, and thus, your committee recommends that the bylaws not be changed so as to allow podiatrists to have such privileges.

It would be impractical to attempt in this report to set out all of the evidence and facts that causes your committee to reach this conclusion.

The primary basis of our consideration and recommendations, fully supported by the testimony and the exhibits offered and considered by the committee, is the fact that Forsyth Memorial Hospital has several orthopaedic surgeons on its staff. All of the functions performed by the podiatrists may be performed by an orthopaedic surgeon. Podiatrists do not receive a medical education or training.

Page 5, lines 1-25

equivalent to that received by orthopaedic surgeons.

By way of illustration, the evidence before the committee indicates that graduate training is available in five schools of podiatry. The graduate podiatry training does not lend itself readily to scrutiny and comparison.

Such critical aspects as teaching laboratories, library and support facilities do not appear to measure up to those in medical and dental schools. Schools of podiatry are free-standing and without university base or university association. The faculties of the podiatry schools are primarily podiatrists with some medical doctors, but the medical doctors are usually referred to as adjunct professors, which was assumed to be visiting professors.

Thus, orthopaedic surgeons as a group can better serve the needs of the whole patient by diagnosing and treating physical and emotional causes, which manifest themselves in terms of foot disorders.

The training of a podiatrist differs from that of orthopaedic surgeons in that podiatrists do not receive internship and residency training equivalent to that of an orthopaedic surgeon.

By way of illustration, podiatric residency training programs are single programs in hospitals with no other medical or surgical residencies, contrary to the medical residency programs which are usually multi-disciplinary with

Page 6, lines 1-25

medical school affiliations.

Put another way, most podiatric post-graduate training programs are in hospitals that lack residency programs in traditional medical specialties, thus providing no cross current of education and information.

Further, the postgraduate training of podiatrists consists of one- or two-year residency programs, as compared to at least four years of training for medical surgical specialists.

In fact, the evidence before your committee indicates that even an orthopaedic surgeon who, if he possesses no

more internship and residency training than that received by a podiatrist, would not be permitted to have surgical privileges at Forsyth Memorial Hospital.

In summary, your committee recommends that the present bylaws, which allow podiatrists to have privileges as allied health personnel be retained, and that the provisions of the bylaws which restrict admitting and surgical privileges to duly qualified physicians and dentists remain unchanged.

The bylaws committee, on August 5th, 1980, unanimously accepted these recommendations.

The executive committee, on August 11th, 1980, unanimously accepted these recommendations.

The members present at the called medical-dental

Page 7, lines 1-2

staff meeting on September the 3rd, 1980, unanimously accepted these recommendations.

Page 46, lines 21-25

MR. ARMFIELD: Mr. Chairman, I'm Ed Armfield. I can't let the opportunity pass of asking Dr. Baker, while he's with us, Dr. Baker, we're between a rock and a hard place here as laymen. We're being told one thing by our staff and particularly with myself, orthopods that I

Pages 47, lines 1-4

respect a great deal, many of whom you've trained. I wonder why we're being told by them unanimously, the whole staff plus the orthopaedists of this hospital, that they would recommend against such a change.

Page 48, lines 23-25

DR. BAKER: It's always going to be that way, but I think your staff, through misinformation, and I don't say

this critically. I'm not belittling their intelligence, wisdom or knowledge and experience. I'm just

Page 49, lines 1-2

saying that I don't think they've acted as an informed group from what the action entails.

Page 54, lines 1-6

CHAIRMAN SIMS: It [the Bylaws] says that the board of trustees shall be responsible for the maintenance of Forsyth Memorial the quality medical care practiced therein. In keeping with this responsibility, they may be guided by the medical-dental staff—so we might want to meet with that executive committee—

Page 62, lines 8-20

MR. GRAVES: One more question. Is it possible for the board to amend the bylaws of the medical staff?

CHAIRMAN SIMS: I'll read that to you. It's on Page 14.

It's in the power of the board of trustees to adopt or amend the medical-dental staff bylaws, rules and regulations shall not be dependent upon ratification by the members of the medical-dental staff. Yes, you may.

MR. LIGON: But the bylaws do require that we go through the process of getting a recommendation of the medical-dental staff before you amend the medical-dental staff bylaws.

Excerpts of Transcripts of Board of
Trustees Meeting October 14, 1982

Page 58, lines 3-25

DR. SHAFFNER: I move that the board accept the recommendation and approve the recommendation of the

medical-dental staff to not change the by-laws with respect to podiatrists having surgical privileges.

CHAIRMAN SIMMS: Is there a second?

DR. NELSON: Second.

DR. SHAFFNER: Mr. Chairman, may I speak to the motion?

CHAIRMAN SIMMS: It's been properly moved and seconded that the recommendation as received from the medical-dental staff to not change the by-laws for co-admitting and surgical privileges be received and adopted.

DR. SHAFFNER: Mr. Chairman ---

CHAIRMAN SIMMS: ---Are you ready for questions?

MR. MARION: No.

MR. ARMFIELD: No.

DR. SHAFFNER: Mr. Chairman, ladies and gentlemen of the board, I have a rather lengthy statement and I beg your indulgence. Mr. Sizemore has questioned my credentials, my right to participate in these deliberations, and my preliminary remarks will, I hope, clarify my status and my involvement.

Page 59, lines 1-25

I speak in support of the recommendation of the medical-dental staff that the by-laws not be amended to allow the admission of podiatrists to the medical-dental staff for surgical privileges. I speak as a board member, but I speak also from the perspective of a physician and surgeon who is not on the active staff of this hospital and who, as a courtesy staff member, has never in my memory admitted a patient to this hospital and who has not consulted on a patient in this hospital for over three years. As a courtesy member I do not have the right to vote or hold office, nor do I attend staff meetings regularly. I've been a mem-

ber of this board since 1969. Mr. Armfield may well remember that he and I, among others, signed the original articles of incorporation on December the 23rd, 1968.

As a board member I've endeavored to help the board in interpreting or clarifying in an unbiased way many recommendations and concerns which have come to the board from the medical-dental staff. I've accepted my continuous reappointment to the board as evidence of the confidence of the board and of the county commissioners in my honesty and integrity in these endeavors. So much for my status.

As regards the current matter, I've attended all board meetings and I did attend but did not speak or vote at the medical-dental staff meeting. I spent, I'm sure, at least ten hours reading transcripts and persuing the

Page 60, lines 1-25

collective exhibits on the matter. I've made phone calls to doctors at Raleigh Community Hospital and New Hanover Hospital in Wilmington. I called Dr. Baker, as he alluded to, seeking clarification of some of his statements made before this board and recorded in the transcript. I called Dr. Wayne Benners, the orthopaedist in Jacksonville, referred to by Dr. Baker. He gave me the same information as recorded in his letter to me, of which you have a copy. I did not ask nor suggest that he write me.

I was present at the last regular board meeting at which Dr. Montgomery read without elaboration the report of the by-laws committee and the recommendation of the staff. I was gratified that other members of the board saw fit to request presentations by the medical staff detailing the reasons for their recommendations. I did request of Dr. Montgomery that I be allowed to speak to the medical staff at its regular meeting on September the 16th. At that time I reviewed for them the presentation by the applicants, their attorneys and Dr. Baker. I listed ques-

tions which these presentations had raised in my mind, and I felt in the minds of other board members, and I recommended that they read the transcript and respond at our called meeting as they saw fit. I had no knowledge beforehand on exactly who would speak before the board or what they would say.

With all this background information, I've read and

Page 61, lines 1-25

reread the articles of incorporation and the by-laws of the Authority and the by-laws of the medical-dental staff. I think it very important that we, as a board, review those parts which bear on our discussion today. We need to have in mind the specific duties and responsibilities we as a board have and to understand the specific duties of the medical staff. Let me read them to you.

Our articles of incorporation state that one of the purposes of the corporation is, and I quote, ". . .To appoint a medical staff composed of such physicians and surgeons as may be recommended by the medical staff who, in the judgment of the board of trustees, are properly qualified to conduct the professional work at the hospital."

The by-laws of the Authority state, and I quote again, ". . .The board of trustees shall be responsible for the maintenance of the hospital and the quality of medical care practiced therein. In keeping with this responsibility they may be guided by the executive committee of the medical staff and its recommendation concerning appointments of members to the medical staff," end quote.

The by-laws also state there shall be an organized group of physicians and dentists who shall be appointed annually by the board of trustees who shall be known at the medical staff and whose duties shall be administered professionally to the patients at the hospital.

Page 62, lines 1-25

The preamble portion of the medical-dental staff portion states, ". . .Whereas it's recognized that the medical-dental staff is responsible for the quality of medical care in the hospital and must accept and discharge its responsibilities, and where it is recognized that the cooperative efforts of the medical-dental staff, chief executive officers, and the governing body, that is, this board, are necessary to fulfill the hospital obligations to its patients. Therefore, the physicians and dentists who practice in this hospital organize themselves into a medical-dental staff in conformity with these by-laws."

In article two some of the elicited purposes of the medical-dental staff are: One, to ensure that all patients admitted to or treated in any of the facilities of the hospital shall receive the best possible care. Two, to ensure a high level of professional performance of all practitioners authorized to practice in the hospital through A, the appropriate delineation of clinical privileges that each practitioner may exercise in the hospital and B, through continuing review and evaluation of each practitioner's performance in the hospital. And three, to initiate and maintain rules and regulations for self-government of the medical-dental staff.

In short, the board has delegated to the medical-dental staff and the staff has accepted the responsibility

Page 63, lines 1-25

of the assurance of maintenance of, quote, "The best possible care" end quote, of patients admitted to the hospital. The staff in its report to the board states that the staff could not ensure the best possible care to all patients if podiatrists are granted admitting and surgical privileges. Representatives of the staff have presented to you, and I believe conscientiously and honestly, their reasons for this conclusion. They cited previous actions to upgrade and maintain high quality care. They expressed the pride of the whole staff in the quality maintained here.

After much study they concluded that the time, breadth, depth and quality of the professional diadactic and clinical training of podiatrists is inferior to that of physicians and dentists with surgical privileges at this hospital. Therefore, to grant surgical privileges to any podiatrist would lower the standard of surgical care in this hospital and this the staff could not do in good conscience.

I feel that the statements and opinion made by medical staff in regard to professional training of podiatrists were not made with a derogatory intent, but rather in a conscientious effort to realistically compare the two disciplines. Similarly, significant differences by virtue of training and emphasis are evident in the training in comparison of other fields that deal with related health services. I can refer to the training and expertise of

Page 64, lines 1-25

clinical psychologists, vis-a-vis psychiatrists, and of optometrists, vis-a-vis ophthalmologists. An analogy, although I admit it's not an exact one, can be made between the qualifications of the licensure of a private pilot limited to visual flight rules and clear weather and those for commercial pilots extensively trained in instrument flying, emergency procedures, etcetera. In no such comparison does the more highly trained disparage the accomplishments of the other. Each does what he's trained to do and can take pride in it.

The applicants have stressed they are not seeking blanket acceptance of all podiatrists but rather individual consideration and credentialing with co-admitting privileges.

Now, this is one aspect of the matter that the physicians did not cover as well as they might. Perhaps the problems with such an arrangement were so obvious that they didn't feel that they should elaborate on them. But let me picture for you what I think the situation would be under such

circumstances. First, the staff, after credentialing, would have to set up a mechanism for observing the performance of the member during his year as a provisional staff member. The logical active staff member to perform this task would be an orthopaedist. Observation of performance requires more than watching technical procedures in the

Page 65, lines 1-25

operating room. It requires the judgment of a man's diagnostic acumen and thoroughness and his ability to anticipate possible complications and prevent them or treat them if he has them. And just as important is the judgment of whether surgery in the first place was indicated and whether the appropriate procedure was performed.

Unless an orthopaedist was the co-admitting physician, and I doubt very much that he'd want to be, he probably would not be assuming any direct liability for the care of the podiatric patient, but his responsibilities as a staff member are great if he is to fulfill his duties to the staff and to this board. It could be very time consuming and without any remuneration.

You might immediately ask why would such observation of a podiatrist be more arduous that that of a provisional staff member with surgical privileges; that of any provisional staff member with surgical privileges. The answer you already have. The previous training, residences and specialty board certifications of a doctor of medicine are known quantities to his peers. It doesn't take much time to assess a man's performance based on standards of that specialty. Can one judge a podiatrist by orthopaedic standards? Your medical staff believes that on the basis of their training podiatrists cannot meet the orthopaedic standards in this hospital for quality in overall care. Yet

Page 66, lines 1-25

they would be required to meticulously observe and judge

all facets of the podiatrist's performance to properly and fairly assess him.

What does the medical staff do if, after observation, they have documented that a man's performance is not up to the standard of this hospital? They can either lower the standard to accommodate him, which is a compromise in the quality of care for a group of patients in this hospital, or they can take corrective action and even restrict or rescind his privileges. But before one can take any corrective action against a staff member or restrict or rescind his privileges, the reasons must be carefully documented. Documentation is hardly ever based on a single incident, rather a pattern of inappropriate act, behavior must be observed. During this time the man's patients are receiving less than ideal care and nothing can be done about it.

The man must then be given due process, the right to a hearing and public review and a final decision by this board. The medical staff by-laws detailing these procedures fill over fifteen pages and it could span a time frame of months for completion. During all this time a man still has his privileges unless the matter is of such urgency that an immediate suspension is mandatory.

Now, I have personal knowledge of a situation involving a surgeon in a North Carolina hospital in which

Page 67, lines 1-25

his peers in the same specialty documented that he had a pattern of doing unnecessary and inappropriate surgery. The problem was compounded by the fact that three other men of the same specialty, that is, those who made the judgment, were partners and thus were suspected of trying to clinch a monopoly in their field by accusing their one-man competition of unethical practice. This had to be resolved by calling in a panel of specialists appointed by the

president of that state's specialty's society to review the findings of the medical staff of that hospital.

A similar or even more knotty problem would occur if the section of orthopaedics of this hospital recommended to the medical staff that the privileges of a podiatrist be restricted or rescinded. I need not belabor these aspects further. I believe you can see why the medical staff recommends that the by-laws not be changed.

Now, I have been speaking from the perspective of a physician and member of the board. Now, let me conclude with a few comments that some of you may have already considered, but all of us should consider this. Hear me out, now. This is the crux of the problem.

If this board does not support the recommendations of the medical staff and thus directs the staff to amend the by-laws to accommodate podiatrists, then we will have a serious internal problem. We will have taken away the

Page 68, lines 1-25

responsibility for the maintenance of high quality care from the doctors and assumed it ourselves. By so doing we would have said to the medical staff that we don't believe them. We would have said that we believe they have been incompetent or dishonest or conspiratory—or what was the other word used today—discriminatory, or all three or four. We would have lost their confidence and their cooperation and I'm sure we'll lose some members of the staff who will resign. And furthermore, we will have put ourselves as a board in jeopardy. Even as has happened to doctors in the past, sometime in the future some patient is going to bring an action against some podiatrist and name the medical-dental staff and this board as parties to this action regarding the quality of care given.

Now, the medical staff is then going to plead no liability. They will have advised the board, but the board ignored

their recommendation. We will be defending ourselves without the help of our medical staff. On the other hand if this board supports the medical staff, this hospital will remain a strong and viral [sic] institution, each facet not opposing each other as has been recommended here—suggested here today, but each facet, the governing board, the chief executive officers and the medical staff will be accepting its responsibilities and cooperating to fulfill the hospital's obligations to its patients. And I don't see

Page 69, lines 1-25

how this board can go against the medical staff and expect the medical staff to cooperate with the board.

If later we're ever forced to change the by-laws we can do so with regret, but at least with the conviction we've done our duty as we saw it. I urge you to support the recommendation of the medical staff and not amend the by-laws.

CHAIRMAN SIMMS: Thank you, Dr. Shaffner.

We now recognize Mr. Koach.

As you know, in the beginning we said that officers and board members may discuss with the board—

MR. SIZEMORE: —I'd like to note an objection.

CHAIRMAN SIMMS: Please note an objection by counsel.

MR. KOACH: At the onset, let me say that I have attended all of the meetings that were held with respect to this matter, and at no time during those meetings did I speak nor was I asked to speak. However, I do think and feel now that it is appropriate that I speak to this board.

There is no point in my reviewing all that has been stated by the applicants and their counsel or by the med-

ical-dental staff. Suffice it to say, if you set aside all the rhetoric on both sides, the heart of the matter is this.

Page 70, lines 1-25

The board of trustees has delegated to the medical-dental staff a responsibility of maintaining the highest level of care at this hospital. Repeatedly that responsibility has been reviewed with the medical-dental staff by means of board of trustee membership and participation in the joint conference committee, as well of reports of quality assurance section, credentials committee and so forth. This board has relied on this medical staff's work and judgment.

The by-laws committee of the medical-dental staff, the executive committee of the medical-dental staff and the medical-dental staff itself have now advised this board again. This board of trustees should not, on one hand, charge the medical-dental staff with this responsibility and historically follow their advise [sic] and then now request that the by-laws be amended. The board should not have both sides of that coin. For it to do other than follow the recommendations of the medical-dental staff means that in medical matters, you substitute your knowledge for that of the physician, and in this particular matter, that you should not do.

As you know, it has been emphasized to the board of trustees that they should amend the by-laws and, in effect, pass the buck back to the medical staff as to whether or not podiatrists get approved. It is my understanding that some trustees may also be feeling that that is the real approach

Page 71, lines 1-16

to this matter since it would leave the decision up to the medical staff. I'm not certain that the trustees fully understand what that means.

If the by-laws are amended so as to allow podiatrists to apply, then the podiatrist's application will have to be measured by the standard of a podiatrist, not by the standard of an orthopaedic surgeon. Consequently, if we amend the by-laws to allow podiatrists to apply, qualified podiatrists measured by the standards of podiatry only will have to be admitted. Consequently, the only way to carry out the recommendation of the medical-dental staff is not to amend the by-laws at all.

This boils down to a single point, that this board should not amend the by-laws if a higher quality of care or treatment now exist on this medical staff.

Thank you, Mr. Chairman.

Page 75, lines 1-25

MR. THOMAS: —I have a question. There's been a suggestion made about observation. Now, we can turn down—we can sustain this motion that's been made. Are we saying we're just going to cut it off, I mean, you don't look at them any more? That—that thing bothers me just a little bit. I came here ready to vote in favor of the medical-dental staff and I still will, but that bothers me a little bit that there's not some, I guess, talking about your lawyer—and we're always looking for an alternative, and it seems to me there's got to be some sort of alternative. I don't—I have to take what our staff says about—I think the real issue is here is podiatrists, not Dr. Cooper, Dr. Johnson, or anybody else, because you're talking about the total. These men, as far as I know, have the highest qualifications, and that's all I've every heard, the highest qualifications.

But it bothers me just a little bit that there is not—it's here and we may be, you know, like Dr. Shaffner says, we might go down fighting. But that's not the point. We're not here to fight, and I'd like to make one other comment. I think some of the things that's been presented to this

board have gotten too personal, gotten away from the issue. I think some of my—and I'm going to pat the lawyers on the back because we're just as bad as the rest of some groups, but I think we can call each other SOB's and

Page 76, lines 1-9

pat each other on the back after it's all over with but—because that's part of what we do. But it does bother me. I'd like to hear what some other people on the board have to say; that if we deny, but can we open a door somewhere. I know people are busy, we're all busy. I know that the doctors are busier than anybody, but it just kind of bothers me a little bit that we just slam the door and say forget it, if there is a possibility—they have offered some sort of alternative and I think we ought to at least talk about it.

Page 79, lines 2-25

CHAIRMAN SIMMS: Mr. Thomas, you know I haven't spoken very much about this situation with respect to the other avenues. As I see it at this time, we only have one avenue and that's to vote on the recommendation that's before us. It seems that the presentation of another avenue was only given today, and it seems to me that that should rightly have been given to the medical-dental staff instead of this particular avenue that was chosen.

The avenue that was chosen was to seek co-admitting and surgical privileges, which would require a change of the by-laws, therefore, that's what we as a board must vote on. We certainly can say after the vote perhaps something else could be studied, but as far as the vote is concerned today if a no vote says close the door, then that's what we have to do. But a yes vote—

MR. HARPER: —Are you saying that this would preclude us from working out any alternatives?

CHAIRMAN SIMMS: It's come to the point now that we vote on this recommendation, because the recommendation is to not allow to change the by-laws for co-admitting and surgical privileges. The observation thing is something different and that's not within this recommendation. It was not presented to the medical-dental staff for study.

Page 80, lines 1-18

MR. THOMAS: Well, we can make one if we want to, a recommendation.

CHAIRMAN SIMMS: You can make recommendations, yeah.

MR. FARABEE: Mr. Chairman, I called for a question five or ten minutes ago.

CHAIRMAN SIMMS: A question's been called for. You've raised the question. There are by my count fifteen people to vote. Is that correct?

All in favor of the motion please raise your right hand. We'll ask the attorney to count.

MR. LIGON: I believe I count fourteen.

CHAIRMAN SIMMS: All opposed to the motion raise your hand.

MR. LIGON: Did Dr. Folds not vote one way or the other? So we only had fourteen eligible.

CHAIRMAN SIMMS: The vote was unaminous. The motion carries.

APPENDIX M

Credentials Committee
Medical-Dental Staff
Page 2
January 5, 1982

PODIATRY: The N. C. Law Section 10, Article 13A, Chapter 131, 126.11 - Procedures for applying for hospital privileges regarding podiatry were read before consideration of the following applications presented by Dr. R. Rose, Chief of Orthopedic Section.

APPLICATION: Carlos T. Cooper, Jr., D.P.M.
Graduated: Ohio College of Podiatric Medicine - 1954
Internship: None
Residency: None
Licensed: N. C. Board of Podiatry Examiners - 1954
Certification: Board Eligible - American Board of Podiatric Surgery

MOTION: After some discussion, the following motion was duly made, seconded and unanimously passed:

INASMUCH AS: (1) THE AD HOC COMMITTEE APPOINTED TO STUDY THE QUESTION OF WHETHER OR NOT PODIATRISTS SHOULD BE ALLOWED TO HAVE ADMITTING AND SURGICAL PRIVILEGES AT

FORSYTH MEMORIAL HOSPITAL SPENT MANY HOURS IN PUBLIC HEARINGS RELATIVE TO THAT ISSUE, AND CONCLUDED THAT PERMITTING PODIATRISTS TO HAVE ADMITTING AND SURGICAL PRIVILEGES WOULD BE INCONSISTENT WITH THE STATEMENT OF THE PURPOSE OF THE MEDICAL-DENTAL STAFF OF THE HOSPITAL WHICH IS TO PROVIDE PATIENTS WITH THE BEST POSSIBLE CARE;

(2) FORSYTH MEMORIAL HOSPITAL HAS SEVERAL ORTHOPEDIC SURGEONS ON ITS STAFF, ALL CAPABLE OF FULFILLING THE FUNCTIONS PERFORMED BY A PODIATRIST AS WELL AS THE ABILITY TO TREAT THE ENTIRE PATIENT; (3) PODIATRISTS DO NOT RECEIVE A MEDICAL EDUCATION OR TRAINING EQUIVALENT TO THAT RECEIVED BY ORTHOPEDIC SURGEONS; (4) ORTHOPEDIC SURGEONS AS A GROUP CAN BETTER SERVE THE NEEDS OF THE WHOLE PATIENT BY DIAGNOSING AND TREATING PHYSICAL AND EMOTIONAL CAUSES WHICH MANIFEST THEMSELVES IN TERMS OF FOOT DISORDERS; (5) THE QUALITY OF CARE AT FORSYTH MEMORIAL HOSPITAL WOULD BE LESSENED OR COMPROMISED IF PODIATRISTS, (POSSESSING LESS EDUCATION, TRAINING AND

EXPERTISE THAN ORTHOPEDIC SURGEONS) WERE APPROVED FOR ADMITTING AND SURGICAL PRIVILEGES; (6) THE REPORT AND RECOMMENDATIONS OF THE AD HOC COMMITTEE WERE APPROVED BY THE EXECUTIVE COMMITTEE AND THE MEDICAL-DENTAL STAFF WITHOUT A DISSENTING VOTE, AND FURTHER APPROVED BY THE BOARD OF TRUSTEES OF THE FORSYTH COUNTY HOSPITAL AUTHORITY WITHOUT A DISSENTING VOTE; AND, (7) THE ACTIONS OF THE COMMITTEE, STAFF AND TRUSTEES WERE CONSISTENT WITH THE OBJECTIVE OF THE HOSPITAL OF PROVIDING QUALITY CARE TO PATIENTS;

THEREFORE, IT IS MOVED THAT THIS COMMITTEE RECOMMEND TO THE EXECUTIVE COMMITTEE THAT THE APPLICATION OF DR. CARLOS T. COOPER, JR. FOR ADMITTING AND SURGICAL PRIVILEGES AT FORSYTH MEMORIAL HOSPITAL BE DENIED.

IT WAS FURTHER MOVED THAT DR. CARLOS T. COOPER, JR. BE ADVISED THAT THE CREDENTIALS COMMITTEE WOULD CONSIDER AN APPLICATION FOR NON-SURGICAL ALLIED HEALTH PRIVILEGES FOR HIM SHOULD HE DESIRE TO APPLY FOR SUCH PRIVILEGES.

APPLICATION:

Ernest Joseph Daniels, D.P.M.
Graduated: Ohio College of Podiatric Medicine - 1966
Internship: None
Residency: Cleveland Foot Clinics of the Ohio College of Podiatric Medicine - 1966-67
Licensed: N. C. Board of Podiatry Examiners - 1966
Certification: Board Eligible - American Board of Podiatric Surgeons

MOTION:

After some discussion, the following motion was duly made, seconded and unanimously passed:

INASMUCH AS: (1) THE AD HOC COMMITTEE APPOINTED TO STUDY THE QUESTION OF WHETHER OR NOT PODIATRISTS SHOULD BE ALLOWED TO HAVE ADMITTING AND SURGICAL PRIVILEGES AT FORSYTH MEMORIAL HOSPITAL SPENT MANY HOURS IN PUBLIC HEARINGS RELATIVE TO THAT ISSUE, AND CONCLUDED THAT PERMITTING PODIATRISTS TO HAVE ADMITTING AND SURGICAL PRIVILEGES WOULD BE INCONSISTENT WITH THE STATEMENT OF THE PURPOSE OF THE MEDICAL-DENTAL STAFF OF THE HOSPITAL WHICH IS TO PROVIDE PATIENTS WITH THE BEST POSSIBLE CARE; (2) FORSYTH

MEMORIAL HOSPITAL HAS SEVERAL ORTHOPEDIC SURGEONS ON ITS STAFF, ALL CAPABLE OF FULFILLING THE FUNCTIONS PERFORMED BY A PODIATRIST AS WELL AS THE ABILITY TO TREAT THE ENTIRE PATIENT; (3) PODIATRISTS DO NOT RECEIVE A MEDICAL EDUCATION OR TRAINING EQUIVALENT TO THAT RECEIVED BY ORTHOPEDIC SURGEONS; (4) ORTHOPEDIC SURGEONS AS A GROUP CAN BETTER SERVE THE NEEDS OF THE WHOLE PATIENT BY DIAGNOSING AND TREATING PHYSICAL AND EMOTIONAL CAUSES WHICH MANIFEST THEMSELVES IN TERMS OF FOOT DISORDERS; (5) THE QUALITY OF CARE AT FORSYTH MEMORIAL HOSPITAL WOULD BE LESSENED OR COMPROMISED IF PODIATRISTS, (POSSESSING LESS EDUCATION, TRAINING AND EXPERTISE THAN ORTHOPEDIC SURGEONS) WERE APPROVED FOR ADMITTING AND SURGICAL PRIVILEGES; (6) THE REPORT AND RECOMMENDATIONS OF THE AD HOC COMMITTEE WERE APPROVED BY THE EXECUTIVE COMMITTEE AND THE MEDICAL-DENTAL STAFF WITHOUT A DISSENTING VOTE, AND FURTHER APPROVED BY THE BOARD OF TRUSTEES OF THE FORSYTH COUNTY HOSPITAL AUTHORITY WITHOUT A

DISSENTING VOTE; AND, (7) THE ACTIONS OF THE COMMITTEE, STAFF AND TRUSTEES WERE CONSISTENT WITH THE OBJECTIVE OF THE HOSPITAL OF PROVIDING QUALITY CARE TO PATIENTS;

THEREFORE, IT IS MOVED THAT THIS COMMITTEE RECOMMEND TO THE EXECUTIVE COMMITTEE THAT THE APPLICATION OF DR. ERNEST JOSEPH DANIELS, FOR ADMITTING AND SURGICAL PRIVILEGES AT FORSYTH MEMORIAL HOSPITAL BE DENIED.

APPENDIX N

EXECUTIVE COMMITTEE
MEDICAL-DENTAL STAFF
Forsyth Memorial Hospital
January 5, 1982

MOTION FROM CREDENTIALS COMMITTEE: The following motion was made by the Credentials Committee:

Inasmuch as: (1) the Ad Hoc Committee appointed to study the question of whether or not podiatrists should be allowed to have admitting and surgical privileges at Forsyth Memorial Hospital spent many hours in public hearings relative to that issue, and concluded that permitting podiatrists to have admitting and surgical privileges would be inconsistent with the statement of the purpose of the Medical-Dental Staff of the Hospital which is to provide patients with the best possible care; (2) Forsyth Memorial Hospital has several orthopedic surgeons on its staff, all capable of fulfilling the functions performed by a podiatrist as well as the ability to treat the entire patient; (3) podiatrists do not receive a medical education or training equivalent to that received by orthopedic surgeons; (4) orthopedic surgeons as a group can better serve the needs of the whole patient by diagnosing and treating physical and emotional causes which manifest themselves in terms of foot disorders; (5) the quality of care at Forsyth Mem-

orial Hospital would be lessened or compromised if podiatrists, (possessing less education, training and expertise than orthopedic surgeons) were approved for admitting and surgical privileges; (6) the report and recommendations of the Ad Hoc Committee were approved by the Executive Committee and the Medical-Dental Staff without a dissenting vote, and further approved by the Board of Trustees of the Forsyth County Hospital Authority without a dissenting vote; and, (7) the actions of the Committee, Staff and Trustees were consistent with the objective of the hospital of providing quality care to patients;

Dr. C. T. Cooper:

Therefore, it is moved that this Committee recommend to the Executive Committee that the application of Dr. Carlos T. Cooper, for admitting and surgical privileges at Forsyth Memorial Hospital be denied.

It was further moved, that Dr. Carlos T. Cooper, Jr., be advised that the Credentials Committee would consider an application for non-surgical allied health privileges for him should he desire to apply for such privileges.

Dr. E. J. Daniels:

Therefore, it is moved that this Committee recommend to the Executive Committee that the application of Dr. Ernest Joseph Daniels, for admitting and surgical privileges at Forsyth Memorial Hospital be denied.

It was further moved, that Dr. Ernest Joseph Daniels, be advised that the Credentials Committee would consider an application for non-surgical allied health privileges for him should he desire to apply for such privileges.

Dr. J. B. Johnson:

Therefore, it is moved that this Committee recommend to the Executive Committee that the application of Dr. James Barry Johnson, for admitting and surgical privileges at Forsyth Memorial Hospital be denied.

It was further moved, that Dr. James Barry Johnson, be advised that the Credentials Committee would consider an application for non-surgical allied health privileges for him should he desire to apply for such privileges.

After some discussion, it was agreed the Executive Committee accept the recommendations of the Credentials Committee, and the following motions were made, seconded and unanimously approved.

MOTION: Therefore, it is moved that this committee recommend to the board of trustees of the Forsyth County Hospital Authority that the application of Dr. Carlos T. Cooper, for admitting and surgical privileges at Forsyth Memorial Hospital be denied.

MOTION: Therefore, it is moved that this Committee recommend to the Board of Trustees of the Forsyth County Hospital Authority that the application of Dr. Ernest Joseph Daniels, for admitting and surgical privileges at Forsyth Memorial Hospital be denied.

MOTION: Therefore, it is moved that this Committee recommend to the Board of Trustees of the Forsyth County Hospital Authority that the application of Dr. James Barry Johnson, for admitting and surgical privileges at Forsyth Memorial Hospital be denied.

APPENDIX O

Excerpts of Transcript of Board of Directors Meeting February 9, 1982

Page 2, lines 3-25

DR. SHAFFNER: Dr. Folds, would you proceed, please, with the next item on the agenda, which is the applicants of podiatry for privileges?

DR. FOLDS: This is regarding the applications by two doctors of podiatric medicine, Carlos Cooper and Joseph Daniels. The following motion came first from—was studied by the credentials committee and then submitted to the executive committee for their approval, so this comes as a motion, really, from the—from the executive committee, stating:

Inasmuch as the ad hoc committee appointed to study the question of whether or not podiatrists should be allowed to have admitting and surgical privileges at Forsyth Memorial Hospital spent many hours in public hearings relative to that issue and concluded that permitting podiatrists to have admitting and surgical privileges would be inconsistent with the statement of the purpose of the medical-dental staff of the hospital, which is to provide patients with the best possible care.

(2) Forsyth Memorial Hospital has several orthopedic surgeons on its staff, all capable of fulfilling the functions performed by a podiatrist, as well as the ability to treat the entire patient.

Page 3, lines 1-25

(3) Podiatrists do not receive a medical education or training equivalent to that received by orthopedic surgeons.

(4) Orthopedic surgeons as a group can better serve the needs of the whole patient by diagnosing and treating

physical and emotional causes which manifest themselves in terms of foot disorders.

(5) The quality of care at Forsyth Memorial Hospital would be lessened or compromised if podiatrists possessing less education, training and expertise than orthopedic surgeons were approved for admitting and surgical privileges.

The report and recommendations of the ad hoc committee were approved by the executive committee and the medical and dental staff without a dissenting vote, and further approved by the board of trustees of the Forsyth County Hospital Authority without a dissenting vote, and the actions of the committee, staff and trustees were consistent with the objectives of the hospital of providing quality care to patients,

Therefore, it is moved that this committee recommend to the board of trustees that the application of Dr. Carlos T. Cooper, Jr. for admitting and surgical privileges at Forsyth Memorial Hospital be denied.

It was further moved that Dr. Carlos T. Cooper, Jr.

Page 4 lines 1-3

be advised that the credentials committee would consider an application for nonsurgical allied health privileges for him, should he desire to apply for such privileges.

Page 12, lines 1-25

DR. SHAFFNER: The bylaw which was just passed states:

In the case of application for privileges by a licensed podiatrist, the application shall be processed in the same manner as applications by a physician, dentist, licensed physician's assistant, or certified nurse practitioner.

Now, if the bylaws—if—if the manner in which the others are processed is on an individual basis, then a podiatrist's application would also be on an individual basis.

MR. HORTON: That has not been done, Dr. Shaffner. These people have been excluded and the recommendation before you is that they continue to be excluded as a group.

DR. SHAFFNER: Mr. Ligon, do you have any response to that?

MR. LIGON: The applications have been considered as individuals. What I understand Mr. Horton to say—and you may or may not have some disagreement about this—is that because they are podiatrists, even though you consider them on their own merits, they cannot become practitioners within the definition in the bylaws.

And it's my understanding of what the committees, the ad hoc committee, credentials committee, and the executive committee, determined was that, inasmuch as they do not

Page 13, lines 1-13

have the training and the experience which the orthopedic surgeon has, that when they are considered individually, on their own merits, you'll reach the conclusion that they cannot be given privileges. So I think maybe it's a matter of semantics, but they are considered on their individual merits. But when they are considered on the individual merits, the committees are saying they are always found, because they are podiatrists and not orthopedic surgeons, to not have the training and the experience which an orthopedic surgeon has, and thereby, when they're considered on the individual merits, they will invariably not be recommended for privileges because they don't have the training and the experience of an orthopedic surgeon.

Page 15, lines 10-20

DR. SHAFFNER: Any other discussion? Can we rest the question?

All in favor or approving the recommendations of the medical-dental staff, please raise your hand.

[Responses in the affirmative]

DR. SHAFFNER: Twelve. Dr. Sayers, I'm not going to count your vote nor Dr. Folds' vote, so we have twelve.

All opposed, please raise your hands.

[Responses in the negative - none]

DR. SHAFFNER: The motion is carried.

APPENDIX P

Excerpts of Minutes of Board of Trustees Meeting February 9, 1982

MEDICAL-DENTAL STAFF:
(Bylaws Addition)

Dr. Folds requested approval of the Board for one addition to the Bylaws of the Medical-Dental Staff. The requested addition is in Article VI, Section 6 relating to applications for privileges by a licensed Podiatrist. (A copy of which is attached to and made a part of these official minutes.) The requested addition has been approved by the Bylaws Committee, Executive Committee and Medical-Dental Staff. Mr. Ligon pointed out that the 1981 changes to the state law requires this to be done and this addition is not a change from what has been the practice in the past.

MOTION:
(Approved)

UPON MOTION DULY MADE, SECONDED AND UNANIMOUSLY PASSED, THE BOARD APPROVED THE ADDITION TO THE BYLAWS OF THE MEDICAL-DENTAL STAFF AS PRESENTED.

(Rules & Regulations Change)

Dr. Folds also requested approval from the Board for a change in the Rules and Regulations of the Medical-Dental Staff. The requested change is in Section C—General Conduct of Care, Number 2 relating to verbal orders. (A copy of which is attached to and made a part of these official minutes.) The requested change has been approved by the Bylaws Committee and the Medical-Dental Staff.

MOTION: (Approved)

UPON MOTION DULY MADE, SECONDED AND UNANIMOUSLY PASSED, THE BOARD APPROVED THE CHANGE TO THE RULES AND REGULATIONS OF THE MEDICAL-DENTAL STAFF AS PRESENTED.

(Podiatry)

Dr. Folds reported that the Medical-Dental Staff had reviewed the request for admitting and surgical privileges for two Podiatrists, Doctors Carlos Cooper and Joseph Daniels. The Credentials Committee reviewed the applications on January 5, 1982 and recommended to the Executive Committee that the requested privileges not be granted. The Executive Committee affirmed the recommendation of the Credentials Committee and recommended to the Board that the requested privileges not be granted. The Podiatrists were notified of their right to appeal the adverse recommendation of the

Executive Committee before the matter was presented to the Board of Trustees. A special Ad Hoc Committee of Dr. William Spencer, Chairman, Dr. Kenneth Carlson and Dr. Keith Kooken met on February 2, 1982 and heard arguments from the Podiatrists and their legal counsel regarding their requests. The Ad Hoc Committee, after considering the arguments of the Podiatriss and their counsel and a review of the previously amassed record, recommended that the Executive Committee affirm its previous decision.

Dr. Folds read the recommendation of the Executive Committee and moved its approval by the Board of Trustees. (A copy of which is attached to and made a part of these official minutes.)

Mr. Ligon explained that Mr. Horton and his partner, Mr. Paul Hendrick, wish to speak to this matter on behalf of Doctors Cooper and Daniels. Mr. Ligon explained that there are three applicants. In addition to the applicants represented by Mr. Horton and Mr. Hendrick, we have an application from Dr. Barry Johnson represented by Mr. Sizemore. The report of the Credentials Committee and Executive Committee from which all of the applicants appealed was heard by the Committee which Dr. Folds appointed in which he referred to. At the

hearing there was an objection raised by Mr. Sizemore, but not by Mr. Horton with respect to the composition of the Committee. The Chairman was actually a member of the Executive Committee and the Bylaws do not permit that to be the case; and, in light of that objection, that Committee did not make a recommendation with respect to Dr. Johnson. Dr. Folds will be appointing a new Committee to deal with Dr. Johnson and that hearing will be held between now and the time of the next Board meeting in March. There will be a report from that Ad Hoc Committee to the Executive Committee and back to the Board of Trustees. This has been discussed with Mr. Horton and he has agreed, on behalf of his clients, that they do not object to the composition of the Ad Hoc Committee and they also do not object to the Board hearing the matter today and thereby waive any Bylaws requirements that give them a specified period between the action of the Executive Committee and the actions of the Board.

Mr. Horton agreed with Mr. Ligon's statement, and rebuttal to the recommendation of the Executive Committee was heard from him on behalf of Doctors Carlos Cooper and Joseph Daniels. Mr. Horton distributed three items for information (copies of

which are attached to and made a part of these official minutes.)

Mr. Ligon stated that the Podiatrists' applications have been considered as individual applications. Mr. Horton maintained that the Podiatrists are being excluded as a group.

Dr. Shaffner then restated the motion on the floor that the Board of Trustees endorse and approve the recommendations of the Medical-Dental Staff that privileges be denied to Doctors Carlos Cooper and Joseph Daniels.

MOTION:
(Approved)

UPON MOTION DULY MADE, SECONDED AND UNANIMOUSLY PASSED, THE BOARD OF TRUSTEES APPROVED THE RECOMMENDATIONS OF THE MEDICAL-DENTAL STAFF THAT ADMITTING AND SURGICAL PRIVILEGES BE DENIED TO DOCTORS CARLOS COOPER AND JOSEPH DANIELS.

NEW BUSINESS:
(Resolution)

Dr. Shaffner distributed for approval by the Board a Resolution Relating to Good Faith Services on Behalf of Trustees, Administration and Medical-Dental Staff Members. (A copy of which is attached to and made a part of these official minutes.)

MOTION:
(Approved)

UPON MOTION DULY MADE, SECONDED AND UNANIMOUSLY PASSED, THE BOARD APPROVED THE RESOLUTION AS PRESENTED.

Mr. Ligon stated that the Resolution would apply to all actions in good faith.

(Outpatient Services)

Mr. Johnson asked what things are being done to promote the Outpatient Services. Mr. Wiles explained the steps that are being taken to promote the services and discussed the various items planned.

(Auxiliary Donations)

Mrs. Green announced that the Auxiliary has donated to the Hospital a total of $13,900 as of November, 1981. She briefly reviewed each item donated and its use. Dr. Shaffner expressed his appreciation to the Auxiliary on behalf of the Board and the entire hospital.

ADJOURNMENT:

There being no further business for discussion, the meeting was adjourned at 4:42 P.M.

Respectfully submitted,

_____

RAYMOND D. THOMAS,
SECRETARY

APPENDIX Q

Excerpts of December 28, 1983 Deposition
of Robert G. Underdal, M.D.

Page 25, lines 12-25

Q. All right, sir, and so at that time you honestly believed that the staff would fight individually and collectively to keep podiatrists off the staff?

A. That was my personal feeling, yes, sir.

Q. All right, sir. And that was the result simply of your talking or listening to individual physicians?

A. Yes, sir.

Q. Now, when you say individually and collectively, what did you mean by that?

MR. THOMPSON: Objection.

THE WITNESS: Well, I'm not sure that those are my verbatim words, but if—you know, if they were verbatim then I think that what I meant was that I could speak surely for myself, that I would do that.

Page 54, lines 17-25

Q. (Mr. Horton) Now, Dr. Underdal, at that meeting you reported on the activity in Winston-Salem with respect to podiatry, didn't you, sir? Directing your attention to the penultimate paragraph. . . .

[Witness examined document]

A. That's correct.

Q. And I believe, Dr. Underdal, that was—you were reporting with reference to applications of certain podiatrists here at Winston-Salem to have surgical privileges

Page 55, lines 1-22

A. —To Forsyth Memorial Hospital.

Q. —At Forsyth Hospital?

A. (No response)

Q. Doctor, who told you that a vote had been taken on that?

A. In—oh, that—that's my own knowledge. That's personal knowledge of mine.

Q. Were you present at the vote?

A. At the vote?

Q. Yes, sir.

A. At—in our staff at the hospital? Yes, sir, uh-huh.

Q. When did it take place?

A. Oh, I don't know, it was taken after the podiatry conferences came up.

Q. Was this a vote of the orthopedic—

A. —Section. Not—

Q. —Section?

A. Not to supervise them?

Q. Yes, sir.

A. Yes, sir.

APPENDIX R

PODIATRY—NCOA POSITION

NATIONAL BACKGROUND:

6 SCHOOLS
1975 - 8,000 PRACTICING
1980 - 15,000 PRACTICING
APA PROJECTS 1/10,000
JCAH RECONSIDERING "RESTRAINT OF TRADE"

STATE BACKGROUND:

57 - 1968
75 - 1975
3 IN HOSPITALS
8 DENIED
11 APPLYING
ARTICLE 12 GENERAL STATUTES

1975 - STATE PUSH - DOCTORS BAKER AND REYNOLDS
REPORT E TABLED 5/75 AFTER NCOA INPUT
NCOA POSITION NECESSARY

REPORT OF POLL:

65 RESPONDING
25 FAMILIAR FIRST-HAND

PERMIT INPATIENT SURGERY	YES - 11 NO - 40
TOTALLY AGAINST	29
SPECIFIC COMPLICATIONS	12
SPECIFIC OVERCHARGE	15
SPECIFIC OVER OPERATE	5

OBJECTIONS:

1. NO PODIATRY BOARDS
2. OVERCHARGE WITHOUT CONTROLS (BCBS)
3. STATE EXAMINING BOARD AUTONOMOUS
4. NO PEER REVIEW ON ANY LEVEL
5. INCOMPETENTS
*6. NO INDEPENDENT EVALUATION
STATE OR NATIONAL
7. NO REQUIRED POST-TRADUAGE TRAINING

IN SUMMARY - NO CONTROLS

ACTIONS POSSIBLE:

1. THE NCOA IS TOTALLY OPPOSED TO THE HOSPITAL PRACTICE OF PODIATRY

2. THE NCOA DISAPPROVES OF THE HOSPITAL PRACTICE OF PODIATRY BUT ACKNOWLEDGES THE INDIVIDUAL HOSPITAL STAFF OPTION TO PERMIT LIMITED INDIVIDUAL PODIATRY PRIVILEGES (? OUTPATIENT ONLY) IN ACCORDANCE WITH QUALIFICATIONS AND FUNCTIONS IN ACCORD WITH PUBLISHED (JCAH ??) AND AAOS GUIDELINE

3. THE NCOA ENCOURAGES EACH HOSPITAL STAFF TO REVIEW ITS BY-LAWS REGARDING STAFF PRIVILEGES AND REVISE THEM ACCORDINGLY

ENCLOSURES:

1. JCAH POSITION
2. AAOS POSITION
3. REPORTS - TABLED REPORT

MY SUGGESTION: THE NCOA STRONGLY DISAP-

PROVES OF THE PRACTICE OF PODIATRY IN ANY ACCREDITED HOSPITAL IN THE STATE BUT ACKNOWLEDGES THAT ANY INDIVIDUAL HOSPITAL STAFF HAS THE OPTION TO PERMIT LIMITED PODIATRY PRIVILEGES. THESE PRIVILEGES SHOULD PERFERRABLY BE ON AN OUTPATIENT BASIS AND ALWAYS STRICTLY IN ACCORD WITH PUBLISHED AAOS GUIDELINES, STATE STATUTES, AND HOSPITAL BY-LAWS. EACH MEMBER OF THE NCOA IS URGED TO REVIEW HIS OR HER LOCAL HOSPITAL BY-LAWS AND WORK TO HAVE THEM REVISED AS NECESSARY.

APPENDIX S

Excerpts of Minutes of
North Carolina Orthopaedic Association
Second Session—Fall Meeting
Winston-Salem—Hyatt House
Dr. James R. Dineen, Presiding
Saturday, 11 October 1975

The meeting was called to order by Dr. Dineen at 8:14 a.m.

Dr. McBryde gave a report on his investigation of podiatry legislation. Discussion followed. Dr. Coonrad made the following motion: That the North Carolina Orthopaedic Association be totally opposed to hospital practice of podiatry. This motion was seconded by Dr. Wooten and discussion followed. The above motion was passed by voice vote with one dissention.

Excerpts of Minutes of N.C. Orthopedic
Association Meeting October 30, 1976

A report on the Podiatry Committee by Dr. McBryde was read by Dr. Neville in Dr. McBryde's absence. The following recommendations were made:

1. That the North Carolina Orthopaedic Association be opposed to hospital practice by podiatrists.

Excerpts of Minutes of
N.C. Orthopedic Association Meeting
September 11, 1980

F. Hospital privileges for podiatrists:

Dr. Holmes read an article from a Winston-Salem newspaper where Dr. Lennox Baker advocated orthopaedic surgeons and podiatrists working together in Winston-Salem. Dr. Underdal, current Chairman of

the Department of Orthopaedic Surgery at Forsyth Memorial Hospital, stated that the staff at that hospital will fight individually and collectively to keep podiatrists off the staff.

The meeting was adjourned at 6:15 P.M.

/s/ JAMES D. HUNDLEY,
JAMES D. HUNDLEY, M.D.
Recording Secretary

Approved _____

Excerpts of Minutes of
N.C. Orthopedic Association Meeting
September 12, 1980

Dr. Robert Underdal then expanded on the activity in Winston-Salem and stated that much of this was now in the hands of attorneys. He believes that a suit will be brought where podiatrists will request co-admitting privileges under orthopaedic supervision. The posture of the medical staff there is that no credentials have been reviewed since they are currently reviewing the art of podiatry. Until this has been found acceptable, individual credentials will not be reviewed. He notes that there are three podiatric applicants for their staff and that one has more than average training. The orthopaedic surgeons have voted that none will supervise podiatrists in that hospital. He is concerned that in the future a patient may sue the hospital for denying him the right to have the doctor of his choice.

Dr. Angus McBryde commented that he thought the NCOA had taken a stand on podiatric hospital privileges in the past. Dr. Dineen indicated that he felt the A.A.O.S. had not taken a stand. The Recording Secretary was asked to review previous minutes and report at the second session of this meeting on Sep-

tember 13, 1980. Dr. Neville pointed out a concern for a class action suit against the NCOA if such a stand is taken.

V. The meeting was then recessed to be reopened on September 13, 1980.

/s/ JAMES D. HUNDLEY
James D. Hundley, M.D.
Recording Secretary

Approved _____

APPENDIX T

Attachment A to Minutes of N.C.
Orthopaedic Association Meeting
of October 15, 1982

COMMENTS BY: Dr. Marshall S. Redding, President
North Carolina Medical Society

When physicians discuss the problems looming over medicine today, you're bound to hear about various health groups making "inroads" into the practice of medicine. These inroads deserve our attention. We *are* outnumbered, let's not be outplanned and outfought as well.

Virtually all of the specialties have had, or soon will have, a confrontation with health groups demanding the right to practice medicine. These groups are aggressive.

Nurses, podiatrists, psychologists, pharmacists, physicians' assistants . . . physical therapists, optometrists, chiropractors, and x-ray technicians . . . all of these have beaten a path to the state legislature hoping they can win a share of what use to be physicians' turf.

I believe we generally agree that people who practice medicine should be medical school graduates. I think we also agree that these groups have limited training . . . and should restrict their activities to those areas where they have some expertise. Ironically, physicians originally created most of these groups to assist the busy physician in areas that did not require the full attention of the physician . . . once he or she had made a diagnosis and treatment was begun.

Emboldened by the *support* of bureaucrats and *misinformed* politicians . . . encouraged by the *benign neglect* of many physicians . . . health groups have used grass roots politics to turn the medical-health world upside down. These groups have skirted the historical prerequisites of

education, training, and experience. They have burst into the world of medicine via legislative fiat . . . and their influence seems to spread while ours wanes.

The real loser in this travesty is the public . . . because the public does not understand the difference between government licensure and the highest quality of care.

Medicine is facing an immense crisis, but physicians are not united. Historically, we have defended quality health care with one voice. But in the recent years, some specialty societies have begun to serve individual interests to the detriment of the profession as a whole.

At the same time, some physicians have ignored or refused to support an individual speciality society in legislative matters . . . simply because the bill in question had no direct effect upon their particular specialities or practices.

So, . . . we've got a problem. What's the solution? The solution is simple but not easy.

First, we've got to recognize that the practice of medicine *does* come under the purview, discretion, and direction of our state legislature. That body can determine the scope of a physician's practice and the freedom with which the physician can pursue it. We've got to abandon the obsolete notion that medical practice is an activity removed from the political arena. We must get involved in politics. We must support our local, state and national medical societies.

Secondly, we must work at the grass roots level and present a united front to the legislature. If legislators and other groups perceive a split in medicine, they will seize that opportunity to divide and conquer. This is happening when specialities perceive themselves as autonomous and neglect the greater strenth and support available to them through organized medicine.

I am sure you remember the american airlines DC-10 bound for Los Angeles that never made it. Shortly after takeoff, the left engine fell from the wing, the plane turned over onto its side and crashed to the ground killing all 272 people aboard. It was the worst disaster in the history of U.S. aviation.

The crash also brought about the grounding of all 138 DC-10's. The grounding order threw domestic and international air service into chaos and resulted in the loss of $2.5 million a day for the eight U.S. airlines.

What caused this disaster? The national transportation safety board's investigation revealed that the plane lost the engine and crashed because a *3-inch bolt* in the engine mounting broke.

A DC-10 is 165 feet wide, 182 feet long, and weights over half a million pounds. Yet, over 272 lives and over $90 million were lost because out of half a million pounds of airline, a 3-inch bolt failed to do its job.

If you are ever tempted to think that the role you play in medicine is too small to be noticed or that you could leave your post and never be missed, remember: You just might be that 3-inch bolt that's holding the whole thing together.

Only if we work together . . . only if we present a united front . . . only if we work to influence our legislators . . . can we preserve a high quality medical care system. It is a question of allowing medical people to make medical decisions. If physicians don't shape the future of medicine, less qualified groups will shape it for us.

That is our just and proper role. No one can take that role from us if we have the will to guard it.

APPENDIX U

UNITED STATES OF AMERICA
BEFORE FEDERAL TRADE COMMISSION

DOCKET NO.

In the Matter of
THE NORTH CAROLINA ORTHOPAEDIC ASSOCIATION,
a corporation.

COMPLAINT

Pursuant to the provisions of the Federal Trade Commission Act, as amended, 15 U.S.C. § 41 *et seq.*, and by virtue of the authority vested in it by said Act, the Federal Trade Commission, having reason to believe that the North Carolina Orthopaedic Association, a non-profit corporation, hereinafter sometimes referred to as respondent, has violated the provisions of said Act, and it appearing to the Commission that a proceeding by it in respect thereof would be in the public interest, hereby issues its complaint, stating its charges as follows:

PARAGRAPH ONE: Respondent, the North Carolina Orthopaedic Association, is a non-profit Corporation organized, existing and doing business under and by virtue of the laws of the State of North Carolina.

PARAGRAPH TWO: Respondent is a professional association organized in substantial part to represent the interests of orthopedic surgeons who practice in North Carolina and the profession of orthopedics in North Carolina. Respondent has approximately 225 members. Many of respondent's activities are of a scientific and educational nature. A significant portion of respondent's activities fur-

thers its members' pecuniary interests. By virtue of its purposes and activities, respondent is a corporation within the meaning of Section 4 of the Federal Trade Commission Act, as amended, 15 U.S.C. § 44.

PARAGRAPH THREE: Most members of the North Carolina Orthopaedic Association provide medical care for a fee. Most, if not all, of respondent's members have been and are now in competition among themselves and with other health care providers in the State of North Carolina.

PARAGRAPH FOUR: In the course of their treatment of patients, North Carolina orthopedic surgeons:

(a) receive and treat patients from other states;

(b) receive substantial sums of money from the federal government and from private insurers for rendering medical services, which money flows across state lines; and

(c) prescribe medicines and medical devices that are shipped in interstate commerce.

PARAGRAPH FIVE: There are approximately 100 podiatrists in North Carolina. Most of them are engaged in the business of providing podiatric services for a fee. Podiatrists in North Carolina are licensed to provide diagnostic, medical and surgical services limited to the foot. Podiatrists compete with orthopedic surgeons in the delivery of some health care services.

PARAGRAPH SIX: In the course of their treatment of patients, North Carolina podiatrists:

(a) receive and treat patients from other states;

(b) receive substantial sums of money from the federal government and from private insurers for rendering medical services, which money flows across state lines; and

(c) prescribe medicines and medical devices that are shipped in interstate commerce.

PARAGRAPH SEVEN: Graduates of podiatry schools and residency programs in podiatry decide where to practice based on a number of factors. One important factor for many podiatrists is their ability to obtain access to hospital facilities that allow them to perform surgery within the scope of their state licenses and in accordance with their training and experience.

PARAGRAPH EIGHT: The acts or practices described herein are in interstate commerce or affect the interstate activities of respondent's members, third parties who pay for orthopedic services, hospitals, podiatrists, or others, and are in or affect commerce within the meaning of Section 5(a)(1) of the Federal Trade Commission Act, 15 U.S.C. § 45(a)(1).

PARAGRAPH NINE: Respondent has agreed, combined, or conspired with some of its members and with others to engage in conduct that unreasonably restrains the practice of podiatry. In particular, they have agreed, combined, or conspired to take action to exclude or unreasonably discriminate against podiatrists who seek, within the scope of their professional licenses as described in Paragraph Five, surgical privileges or access to or use of hospital facilities. As part of or in furtherance of the agreement, combination, or conspiracy regarding podiatry, respondent passed two resolutions opposing the hospital practice of podiatry, its members were enjoined to review or change hospital bylaws accordingly, and some of respondent's members have participated in such review or change of hospital bylaws.

PARAGRAPH TEN: The purposes or effects and the tendency and capacity of the agreement, combination, or conspiracy and the acts and practices described in Paragraph Nine of this complaint are and have been to unreasonably restrain competition and to deny to the public the benefits of competition in the following ways, among others:

(a) Competition based on price, quality and service in the delivery of professional health services has been lessened;

(b) The ability of patients and prospective patients to select a licensed practitioner of their choice has been hindered;

(c) The ability of podiatrists to compete with medical doctors has been restricted; and

(d) Podiatrists have been discouraged from practicing in North Carolina because of the difficulty of obtaining hospital privileges.

PARAGRAPH ELEVEN: The aforesaid agreement, combination, or conspiracy and the acts and practices of respondent constitute unfair methods of competition in violation of Section 5 of the Federal Trade Commission Act, 15 U.S.C. § 45. Such agreement, combination, or conspiracy and the acts and practices of respondent are continuing and will continue in the absence of the relief herein requested.

WHEREFORE, THE PREMISES CONSIDERED, the Federal Trade Commission, on this ___day of ___, 1985, issues its complaint against respondent.

By the Commission.

/s/ EMILY H. ROCK
Secretary

S E A L

UNITED STATES OF AMERICA
BEFORE FEDERAL TRADE COMMISSION

FILE NO. 841 0038
AGREEMENT CONTAINING
CONSENT ORDER TO
CEASE AND DESIST

In the Matter of
THE NORTH CAROLINA ORTHOPAEDIC ASSOCIATION,
a corporation.

The Federal Trade Commission having initiated an investigation of certain acts and practices of the North Carolina Orthopaedic Association, a non-profit corporation, hereinafter sometimes referred to as proposed respondent, and it now appearing that proposed respondent is willing to enter into an agreement containing an order to cease and desist from the use of the acts and practices being investigated,

IT IS HEREBY AGREED by and between the North Caroling Orthopaedic Association, by its duly authorized officers and its attorneys, and counsel for the Federal Trade Commission that:

* * * *

Order

I

* * * *

II

IT IS ORDERED that respondent shall cease and desist from, directly or indirectly or through any corporate or

other device, in or in connection with respondent's activities as a professional non-profit association in or affecting commerce, the following:

A. Entering into, continuing, maintaining, adhering to, acquiescing in, or aiding and abetting any agreement, combination or conspiracy to unreasonably exclude, unreasonably discriminate against, or place unreasonable restrictions on any podiatrist seeking or having surgical privileges at any hospital or access to or use of any hospital facilities, when such privileges, access or use is permitted under North Carolina law;

B. Inducing or seeking to induce any hospital, hospital medical staff, physician, or other person or entity to obstruct or deny surgical privileges at any hospital or access to or use of any hospital facilities by the podiatric profession or any licensed podiatrist through any representation that is false or deceptive within the meaning of the Federal Trade Commission Act.

* * * *

V

IT IS FURTHER ORDERED that respondent shall notify the Commission of any proposed change in its organization at least thirty (30) days prior to the proposed change in respondent, such as dissolution, assignment, or sale resulting in the emergence of a successor corporation or association, or any other change that may affect compliance with this order.

Signed this 7th day of November, 1985.

/s/ A.T. Fenneth, M.D.

President, The North Carolina Orthopaedic Association

/s/ George L. Little, Jr.
Counsel for The North Carolina Orthopaedic Association

/s/ F. Joseph Treacy Jr.
Counsel for The North Carolina Orthopaedic Association

/s/ Douglas B. Brown
Douglas B. Brown
Counsel for the Federal Trade Commission

/s/ Charles Peterson
Charles Peterson
Counsel for the Federal Trade Commission

APPROVED:

/s/ Harold E. Kirtz
Harold E. Kirtz
Assistant Regional Director

/s/ Paul K. Davis
Paul K. Davis
Regional Director

/s/ Walter T. Winslow
Walter T. Winslow
Acting Director
Bureau of Competition

APPENDIX V

UNITED STATES OF AMERICA
BEFORE FEDERAL TRADE COMMISSION

DOCKET NO.

In the Matter of
HEALTH CARE MANAGEMENT CORPORATION,
a corporation, and

MEDICAL STAFF OF NORTH MOBILE COMMUNITY HOSPITAL,
an unincorporated association.

COMPLAINT

Pursuant to the provisions of the Federal Trade Commission Act, as amended, 15 U.S.C. §41 *et seq.*, and by virtue of the authority vested in it by said Act, the Federal Trade Commission, having reason to believe that the named respondents have violated the provisions of Section 5 of the Federal Trade Commission Act, and it appearing to the Commission that a proceeding by it in respect thereof would be in the public interest, hereby issues this complaint, stating its charges as follows:

PARAGRAPH ONE: Respondent Health Care Management Corporation is a for-profit corporation existing under the laws of the State of Georgia. North Mobile Community Hospital ("the Hospital") is a division of Health Care Management Corporation, operating a general acute care hospital in the Mobile, Alabama, metropolitan area. The principal physical facilities of the Hospital are located at Hartley and Baker Roads, Satsuma, Alabama 36572. Health Care Management Corporation is a corporation within the meaning of Section 4 of the Federal Trade Commission

Act, as amended, 15 U.S.C. §44, and is subject to the Commission's jurisdiction.

PARAGRAPH TWO: Respondent Medical Staff of North Mobile Community Hospital ("the Medical Staff") is an unincorporated association, organized and existing under the laws of the State of Alabama, and is located at the Hospital. It is composed of the physicians and other practitioners who have been granted privileges to attend patients at the Hospital.

PARAGRAPH THREE: Most, if not all, of the members of the Medical Staff are engaged in the business of providing medical services for a fee. Except to the extent that competition has been restrained as herein alleged, most, if not all, of the Medical Staff's members have been and are now in competition among themselves and with other health care providers in the Mobile metropolitan area.

PARAGRAPH FOUR: Membership on the Medical Staff provides important economic benefits to the individual members, and it allows a practitioner to admit and treat patients at the Hospital and provides the opportunity for other professional benefits to its members. The Medical Staff is organized for the profit of its members, is a corporation within the meaning of Section 4 of the Federal Trade Commission Act, as amended, 15 U.S.C. § 44, and is subject to the Commission's jurisdiction.

PARAGRAPH FIVE: Physicians in the Mobile, Alabama, metropolitan area charge fees and collect payments for their services that, in substantial part, are paid directly or indirectly with Federal funds or funds received interstate from insurance companies and from other payers. The flow of said funds is affected by competition among physicians in the Mobile metropolitan area and by the acts and practices of the Medical Staff and its members as hereinafter alleged. Moreover, medical practitioners in the Mobile metropolitan area treat out-of-state patients, and the ability of a medical practitioner to obtain hospital priv-

ileges may influence his or her decision to move to and practice in the Mobile metropolitan area. These acts and practices are in commerce or affect commerce within the meaning of Section 5 of the Federal Trade Commission Act, as amended, 15 U.S.C. § 45.

PARAGRAPH SIX: On January 14, 1981, a podiatrist applied to the Hospital for certain surgical privileges within the scope of his Alabama podiatry license. The Hospital encouraged the Medical Staff to grant privileges to the podiatrist because the Hospital desired to increase its occupancy rate and the utilization of its facilities.

PARAGRAPH SEVEN: On September 2, 1981, the Hospital granted that podiatrist certain podiatric surgical privileges on the condition that he co-admit his patients with a medical doctor, in conformance with the standards of the Joint Commission on the Accreditation of Hospitals then in effect. Soon after that date, the podiatrist began to co-admit patients with at least two members of the Medical Staff.

PARAGRAPH EIGHT: In July, 1982, some members of the Medical Staff, who were in competition with podiatrists, began a drive to prevent podiatrists from performing surgery at the Hospital. Thereafter, beginning at least as early as October, 1982, some members of the Medical Staff, the Medical Staff acting as a combination of its members, and the Hospital joined in a combination and conspiracy to pressure individual physicians not to co-admit patients with any podiatrist and to impose on the practice of podiatry within the Hospital unreasonable restrictions that are not reasonably related to legitimate quality of care grounds.

PARAGRAPH NINE: In furtherance of the aforesaid combination and conspiracy to impose on the practice of podiatry within the Hospital unreasonable restrictions that are not reasonably related to legitimate quality of care grounds, the Medical Staff, some members of the Medical

Staff, and the Hospital engaged in the following acts and practices, among others:

A. Some members of the Medical Staff pressured individual physicians not to co-admit patients with any podiatrist;

B. The Medical Staff imposed restrictions unreasonably limiting the practice of podiatry within the Hospital:

1. The Medical Staff imposed severe restrictions regarding the supervision of podiatrists by members of the Medical Staff. Those restrictions were not reasonably related to quality of care and had the effect of raising costs and limiting the practical ability of the podiatrists to use the Hospital's surgical facilities;

2. The Medical Staff required all podiatrists who sought surgical privileges to have completed a three-year approved residency. However, the Medical Staff had no knowledge concerning the relevancy of the training received in the second and third years of podiatric residency training to the specific procedures for which privileges were requested, and it had no objective basis to believe that the three-year residency requirement was reasonably necessary to ensure quality of care for the specific procedures that the podiatrists sought privileges to perform. The effect of a three-year residency requirement would be to exclude virtually every podiatrist in the United States from obtaining surgical privileges; and

3. The Medical Staff prohibited podiatrists from attending Medical Staff meetings; and

C. The Hospital approved or enforced these restrictions and thereby joined in the aforesaid combination and conspiracy.

PARAGRAPH TEN: As a result of the aforesaid combination, conspiracy, and conduct, the only podiatrist who retained privileges could not admit and treat surgical patients at the Hospital because no member of the Medical Staff would co-admit patients with him. Other podiatrists were denied privileges there because of the aforesaid combination, conspiracy, and conduct.

PARAGRAPH ELEVEN: The purposes or effects and the tendency and capacity of the combination, conspiracy, conduct, and practices described in paragraphs Eight, Nine, and Ten are and have been to restrain trade unreasonably and hinder competition between medical doctors and podiatrists for the care of the foot in the Mobile metropolitan area, and to deprive consumers of the benefits of competition in the following ways, among others:

A. Patients have been limited in their ability to choose among a variety of alternative types of health care providers competing on the basis of price, service, and quality;

B. Other hospitals may be deterred from granting reasonable surgical privileges to podiatrists; and

C. Podiatrists may be deterred from entering into practice in the Mobile area because of the lack of reasonable surgical privileges.

PARAGRAPH TWELVE: The combination, conspiracy, and conduct described above constitute an unfair method of competition in violation of Section 5 of the Federal Trade Commission Act, 15 U.S.C. § 45. Such combination, conspiracy, and conduct are continuing and will continue absent the entry against respondents of appropriate relief.

WHEREFORE, THE PREMISES CONSIDERED, the Federal Trade Commission, on this ___day of _____, 1985, issues its complaint against respondents.

By the Commission.

Emily H. Rock
Secretary

SEAL

UNITED STATES OF AMERICA
BEFORE FEDERAL TRADE COMMISSION

FILE NO. 841-0116

In the Matter of
HEALTH CARE MANAGEMENT CORPORATION,
a corporation, and

MEDICAL STAFF OF NORTH MOBILE COMMUNITY HOSPITAL,
an unincorporated association.

AGREEMENT CONTAINING CONSENT ORDER TO CEASE AND DESIST

The Federal Trade Commission having initiated an investigation of certain acts and practices of the North Mobile Community Hospital, a division of Health Care Management Corporation, and of its Medical Staff ("proposed respondents"), and it now appearing that proposed respondents are willing to enter into an agreement containing an order to cease and desist from the use of the acts and practices being investigated,

IT IS HEREBY AGREED by and between proposed respondents, by their duly authorized officers and attorneys, and counsel for the Federal Trade Commission that:

* * * *

ORDER

I

* * * *

II

IT IS ORDERED that Health Care Management Corporation, in connection with the ownership and operation of the Hospital, shall cease and desist from, directly or indirectly or through any device, entering into, continuing, maintaining, adhering to, acquiescing in, or aiding and abetting any agreement, combination, or conspiracy to unreasonably restrict the practice of podiatry permitted under Alabama law, in or affecting commerce, as "commerce" is defined in the Federal Trade Commission Act, including but not limited to any agreement, combination, or conspiracy to:

A. Coerce or encourage any staff member not to co-admit a podiatrist's patient or otherwise associate professionally in the treatment of that patient with a podiatrist who is lawfully licensed in the State of Alabama and has been granted surgical privileges by the Hospital for the procedures for which the patient is admitted;

B. Enact, impose, or approve any bylaw, rule, regulation, policy, or practice that requires an amount of residency training for podiatrists that is not reasonably related to legitimate quality of care grounds with regard to the specific surgical procedures for which privileges are requested;

C. Enact, impose, or approve any bylaw, rule, regulation, policy, or practice relating to the practice of podiatry that is not reasonably related to legitimate quality of care grounds and that unreasonably restricts the practice of podiatry at the Hospital or unreasonably discriminates against podiatrists; or

D. Enact, impose, or approve any bylaw, rule, regulation, policy, or practice that restricts

any podiatrist who has been granted privileges by the Hospital from attending Medical Staff meetings.

III

IT IS FURTHER ORDERED that the Medical Staff shall cease and desist from, directly or indirectly or through any device, in or affecting commerce, as "commerce" is defined in the Federal Trade Commission Act, the following:

A. Coercing or encouraging any staff member not to co-admit a podiatrist's patient or otherwise associate professionally in the treatment of that patient with a podiatrist who is lawfully licensed in the State of Alabama and has surgical privileges at the Hospital for the procedures for which the patient is admitted;

B. Enacting, imposing, participating in, recommending, or suggesting any restriction, bylaw, rule, regulation, policy, or practice that requires an amount of residency training for podiatrists that is not reasonably related to legitimate quality of care grounds with regard to the specific surgical procedures requested;

C. Enacting, imposing, participating in, recommending, or suggesting any restriction, bylaw, rule, regulation, policy, or practice relating to the practice of podiatry that is not reasonably a related to legitimate quality of care grounds and that unreasonably restricts the practice of podiatry or unreasonably discriminates against podiatrists; or

D. Enacting, imposing, participating in, recommending, or suggesting any restriction, bylaw, rule, regulation, policy, or practice that re-

stricts any podiatrist who has been granted privileges by the Hospital from attending Medical Staff meetings.

IV

IT IS PROVIDED that this Order shall not be construed to prohibit the Hospital or the Medical Staff or its members from engaging in credentialling, corrective action, utilization review, quality assurance, peer review, or hospital policy-making activities at the Hospital, where such conduct by the Hospital or the Medical Staff neither constitutes nor is part of any agreement, combination, or conspiracy whose purpose, effect, or likely effect is to impede unreasonably the practice of podiatry at the Hospital as permitted under Alabama law.

V

IT IS FURTHER PROVIDED that nothing in this Order shall require the Medical Staff or the Hospital to violate any Federal or State law.

VI

* * * *

VII

IT IS FURTHER ORDERED that within sixty (60) days after the date of service of this Order, the Medical Staff and Health Care Management Corporation shall revise or change the respective restrictions, bylaws, rules, regulations, policies, and practices of the Medical Staff and the Hospital to conform with the provisions of this Order and shall eliminate, modify, and change any restrictions, bylaws, rules, regulations, policies, or practices that unreasonably restrict the practice of podiatry at the Hospital. A copy of all such changes shall be included in the report required under Section VI (C) of this Order.

VIII

IT IS FURTHER ORDERED that each respondent notify the Commission of any proposed change in its organization that may affect compliance obligations arising out of this Order at least thirty (30) days prior to such proposed change.

Signed this 2nd day of July, 1985.

/s/ James S. Loudermilk
Health Care Management Corporation
By: James S. Loudermilk,
President

/s/ Hugh P. Boswell
Medical Staff of North Mobile Community Hospital
By: Hugh P. Boswell, M.D.
President

/s/ David W. Mernitz
David W. Mernitz
Stark, Doninger, Mernitz & Smith
Counsel for Health Care Management Corporation

/s/ Douglas B. Brown
Douglas B. Brown
Counsel for the Federal Trade Commission

APPROVED:

/s/ Harold E. Kirtz
Harold E. Kirtz
Assistant Regional Director

/s/ Paul K. Davis
Paul K. Davis
Regional Director
Atlanta Regional Office

/s/ Timothy J. Muris
Timothy J. Muris
Director
Bureau of Competition

APPENDIX W

MEDICAL CONFERENCE

Forsyth Memorial Hospital

September 19, 1980

Craig Room

The Medical Conference of Forsyth Memorial Hospital began at 9:00 a.m. with the following in attendance:

Austin, Dr. William
Bhatti, Dr. M. A.
Boyette, Dr. G. T.
Butler, Dr. R. N.
Cullen, Dr. Peter
Dorsett, Dr. F. I.
Early, Dr. I. G.
Fina, Dr. Michael
Fromson, Dr. Gerald
Fromson, Dr. Jean
Gaddy, Dr. J. E.
Glen, Dr. Dulaney
Griffin, Dr. A. O.
Hampton, Dr. J. H.
Harris, Dr. Dean
Harris, Dr. Jimmie
Helms, Dr. J. B.
Hough, Dr. William
Imamura, Dr. H. S.
Jones, Dr. B. N.
Keith, Dr. Ted
Klein, Dr. Steve
Lambeth, Dr. W. A.
Lowder, Dr. Steven
MacMahon, Dr. Marcus
McCall, Dr. William
Newsome, Dr. A. R.

Orbock, Dr. Jacob
Perry, Dr. Irvin
Perryman, Dr. O. C.
Philipp, Dr. R. J.
Phillippi, Dr. Paul
Reid, Dr. C H.
Roberts, Dr. Jesse
Roufail, Dr. W. M.
Rubin, Dr. Michael
Schmid, Dr. Herman
Setty, Dr. J. R.
Slatkoff, Dr. Marc
Smith, Dr. J. B.
Smith, Dr. R. L.
Spencer, Dr. W. J.
Story, Dr. L. J.
Stringer, Dr. Lew
Sugg, Dr. W. C.
Tettamanti, Dr. H.
Trujillo, Dr. Jaime
Wiggins, Dr. J. C.
Williams, Dr. S. C.
Yopp, Dr. James
Dudley, Dr. J. B.
White, Dr. James

Discussion: Dr. William McCall discussed the major points of allergic rhinitis which basically is a genetic dominant problem. An audiovisual presentation of insect sting sensitivity was presented. The studies on whole body insect vaccines have shown little beneficial effects. Specific venom extracts do have an improved effect in desensitization and can be evaluated by measurement of specific levels of immunoglobulins.

RESOLUTION: The following resolution was passed unanimously by the Division of Medicine:

Resolution to the Members of the Forsyth County Hospital Authority from the Division of Medicine:

The Division of Medicine has carefully considered the request for the Staff of Forsyth Memorial Hospital to revise its By-Laws in order that qualified Podiatrists may have Co-admission and Surgical Privileges of the foot. Since the members of the Division of Medicine are the physicians most likely to be asked to Co-admit with the Podiatrists, this subject becomes a personal involvement.

After many hours of deliberation, it is our unanimous opinion, that the podiatric services that require the patient be admitted to the hospital, would be managed better and more safely by a physician-surgeon than by a Podiatrist. We do favor the continuation of the present limited Podiatric privileges: that upon the request of a physician member of the staff a qualified Podiatrist may render non-surgical services or consultation to an inpatient or as more commonly is the practice, in the Podiatrist's office.

We recommend that the Trustees concur with the Medical-Dental Staff of Forsyth Memorial Hospital not to revise the By-Laws as requested by the Podiatrists.

Adjourned: The meeting was adjourned at 10:00 a.m.

Next Meeting: The next meeting will be held September 26, 1980.

/s/ W. A. LAMBETH, JR., M. D.
W. A. LAMBETH, JR., M.D.
Vice President for Medical Affairs

WAL/rjm

APPENDIX X

MEMBERS:

Mrs. Wymene S. Valand, Chairman
Senator Marshall A. Rauch, Vice Chairman

Rep. David W. Bumgardner, Jr.
Mrs. Willie Mae Carney
Mrs. Nancy Chase
Mr. Emanuel S. Douglas
Dr. Jack D. Fleer
Rep. Richard R. Grady
Sen. Joseph J. Harrington
Sen. W. Craig Lawing
Rep. Edd Nye
Mrs. Janet W. Pickler

STAFF:

Paul C. Jordan, Executive Director
George H. Fleming
Benjamin Gilbert
Carolyn I. Ingram
Sarah J. Murphy
Ann P. Poole
Warren L. Tadlock

STAFF REPORT ON
NORTH CAROLINA STATE BOARD
OF
PODIATRY EXAMINERS

August, 1980

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INTRODUCTION

Podiatrists play the major role in meeting the foot care needs of the public. While medical doctors, particularly orthopedists and general practitioners, provide similar services, the majority of patient vists [sic] for foot problems are to podiatrists. Because of the quality of his professional training, the podiatrist is skilled in performing virtually every kind of therapeutic procedure—including most surgery—that might be required to prevent or correct any ailment of the foot.

Given the important position they occupy in providing primary foot care, the chronic shortage of podiatrists in North Carolina creates problems for consumers. According to statistics supplied by The Health Services Research Center at The University of North Carolina, only 70 licensed podiatrists are now actively practicing in the State. Seventy-five counties have no resident podiatrist and this list includes 18 with populations in excess of 50,000. As might be expected, North Carolina's per capita supply of qualified podiatrists falls far below the national average.

An important objective of any system of occupational regulation is the creation of a licensing procedure that does everything possible to ensure an adequate supply of qualified practitioners. After a review of the podiatry licensure law and related health care legislation, the staff concludes that more can be done to accomplish this goal. Legislation should be enacted to permit podiatrists to be considered for hospital staff privileges in much the same manner that physicians and dentists are today. Further, the practice act should provide a means by which qualified out of state practitioners could be considered for licensure without examination. The staff also believes that the Board's testing requirements should be modified to lessen

the administrative burden on initial applicants who have previously passed competency exams of equivalent depth and coverage. In a related matter, the broad restrictions on professional advertising and solicitation now contained in the licensing law should be amended to limit their coverage to the issue of false, deceptive or misleading content.

The Board's policy regarding the investigation of consumer complaints raises a question of procedure which is discussed here. Finally, the staff recommends the addition of public members to the Board and a change in the Board selection process.

* * * *

ISSUE #2

SHOULD PODIATRISTS BE ELIGIBLE TO BE CONSIDERED FOR HOSPITAL PRIVILEGES IN NORTH CAROLINA?

Nationally, at least 55% of all licensed podiatrists are eligible to be considered for hospital privileges along with physicians, dentists and other health care professionals. The percentage of podiatrists performing hospital surgery has risen from 30% in 1970 to 40% in 1974. Practitioner eligibility for clinical privileges is clearly a growing trend as thirteen states have enacted either legislation or administrative regulations to accomplish this end within the past several years. According to the American Podiatry Association, podiatrists may now be considered for privileges in Virginia, South Carolina, Maryland and Florida. Such is generally *not* the case for podiatrists practicing in North Carolina.

With the improved educational and testing requirements for licensure today, the objections to extending hospital privileges to podiatrists are no longer persuasive. Representatives of the profession maintain that podiatric education has improved significantly. The professional program

consists of two years of preclinical preparation and two years of clinical training. The preclinical curriculum is virtually identical to that of the medical schools, stressing the basic biological sciences such as anatomy, physiology, microbiology and pathology. The clinical training includes an externship and courses in podiatry, general medicine and surgery, dermatology, radiology, orthopedics and neurology. Though they concentrate extensively on the foot and leg, podiatric students learn general diagnostic and therapeutic procedures for all body systems.

The disadvantages of the blanket exclusion of podiatrists from consideration for hospital privileges are apparent. The Montana sunset report on its Board of Podiatry contends that keeping podiatrists out of hospitals prevents them from performing surgical procedures that they are already licensed to perform, thereby imposing an unnecessary restriction on the public's foot care options. Patients needing foot surgery administered in a hospital setting would be forced to seek a physician for the operation. If a podiatrist can perform surgery in his office, it is difficult to understand why he shouldn't be permitted to do the same thing in a hospital. Besides limiting foot care alternatives, the unavailability of hospital privileges is likely a factor in discouraging the entry of more podiatrists into the State. Since they can now be considered for privileges in Virginia and South Carolina, incoming practitioners might be more likely to choose one of these states instead.

In North Carolina, hospital by-laws generally do not provide for podiatrists to be considered for clinical privileges. A bill was introduced in the 1979 General Assembly to amend the Hospital Licensing Act, G.S. §131, Article 13A, and require all hospitals in the state to set reasonable standards and procedures to be used in considering applications by medical doctors, dentists and podiatrists for staff membership and clinical privileges. The standards would base selection upon the *training, experience and*

clinical competence of the individual applicant—a case by case approach. The proposed amendment, then, would not require that they extend privileges to podiatrists—only that they consider them in the same manner as they would physicians and dentists.

The North Carolina Hospital Association has apparently endorsed the principle of podiatrist eligibility for staff privileges. A February 1, 1980 NCHA memo to all member institutions suggested that they establish procedures for considering podiatrists for clinical privileges in the same manner as physicians, osteopaths and dentists.

The staff believes that podiatrists should be eligible for consideration for hospital privileges. The case by case approach endorsed in the 1979 bill is a responsible way of dealing with the situation. Legislation incorporating the features of that bill could be included in the Hospital Licensing Law or the Podiatry practice act itself.

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86-471

NO.

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Supreme Court of the United States

OCTOBER TERM, 1986

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INC., et al.,

Respondents.

PETITION FOR A WRIT OF CERTIORARI TO THE
UNITED STATES COURT OF APPEALS
FOR THE FOURTH CIRCUIT

BRIEF FOR THE RESPONDENTS IN OPPOSITION

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INTRODUCTION

This Brief is filed jointly on behalf of all respondents. The briefs filed by various defendants or defendant groups in the Trial Court discussed a number of defenses which we feel the Trial Court could

have appropriately used as a basis for allowing respondents' motions for summary judgment. However, inasmuch as Judge Erwin used the most obvious flaw in petitioners' case--absolutely no evidence of an antitrust conspiracy--it was not necessary to reach those bases.[1/]

What the petitioners list as the questions involved will be discussed subsequently in this Brief. However, the respondents respectfully submit to the Court that the Petition is factually inaccurate in a number of respects, and misleading in several others. Consequently, the respondents desire to use the first few pages of their allocation to present what we submit is a more accurate statement of the facts and background.

[1/] The Court of Appeals for the Fourth Circuit reached the same conclusion, stating: "Not only have appellants failed to proffer evidence from which a conspiracy can reasonably be inferred, appellees have tendered affidavits denying any anti-competitive conspiracy." (Page 8a of Pet. App.).

STATEMENT OF FACTS

In order to carry out its duty of insuring "that all patients admitted to or treated in any of the facilities, departments, or services of the hospital [Forsyth Memorial Hospital (hereinafter "FMH")] shall receive the best possible care" (Bylaws of FMH, Art. II, Sec. 1], (JA at 196)[2/] the Bylaws adopted by the Hospital's Board of Trustees provide that only licensed physicians and dentists who can sufficiently document their background, experience, training, demonstrated competence, adherence to professional ethics, good reputation, and ability to work with others will qualify for staff membership (JA at 196). The staff and its committees evaulate applications for staff privileges and make recommendations to the Board, and

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[2/] JA refers to Joint Appendix filed with Fourth Circuit Court of Appeals.

the Board passes on all such applications by measuring them against the stated staff membership criteria.[3/] This accords with the Board's responsibility pursuant to State law.

The Bylaws in question, and their implementation resulting in the denial of staff privileges to anyone unable to satisfy the Board's qualifications and policies regarding education and training, comply with Joint Commission on the Accreditation of Hospitals (hereinafter "JCAH") standards. These restrict medical staff membership to those licensed

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[3/] On page 6 of the Petition, the petitioners state that the medical staff determines "who shall be granted clinical privileges subject only to limited appellate review by the Board." This is inaccurate. The Board of Trustees is the only body, pursuant to State law and the Bylaws, with authority to grant or deny clinical privileges. The Board receives the advice and recommendations from the Executive Committee, but the Board makes the decision. Consequently, it is the Board of Trustees (consisting of lay persons--housewives, bankers, school teachers, lawyers, plant employees, etc.) that "determines who shall be granted clinical privileges", and not the medical staff as represented in the Petition.

to practice medicine and licensed dentists unless otherwise provided by law, and give hospitals the option of granting or denying clinical privileges to individual podiatrists who are appropriately licensed. (JA at 207). Furthermore, FMH Bylaws allow podiatrists to have allied health privileges but petitioners in this case have never sought those. The Board of Trustees' determination of whether or not a podiatrist applicant for surgical privileges is to be approved simply cannot ignore the differences in education and training of physicians and surgeons versus podiatrists and other allied health professionals. At FMH, even a surgeon who does not have any more residency training than the petitioners have would not be permitted to do foot surgery. This has been the rule for more than 20 years, long before these podiatrists applied.

Petitioners applied for staff privileges

at FMH in April, 1980. Upon receipt of the applications, the determination was made that the appropriate way of dealing with the applications was to convene the Bylaws Committee and have the Bylaws Committee conduct an in-depth study into the education and training of podiatrists in general, and the applicants in particular. The idea was to have a thorough and objective study of the qualifications of podiatrists in order to determine whether or not the Bylaws should be amended to allow podiatrists admitting and surgical privileges, as well as allied health privileges already available to them. Thus, three physicians who do not engage in foot surgery, and thus do not compete with the applicants, were appointed to serve as the Bylaws Committee. The Bylaws Committee held many hours of hearings over a number of days regarding the education and training of podiatrists

in general and the applicants specifically. The President of the Medical Staff put a notice on the bulletin board inviting all persons who had knowledge concerning the education, training and work of competent podiatrists to attend and share that information with the Committee. The podiatrists were represented by counsel throughout the hearings, engaged a court reporter to record all of the evidence, and brought in witnesses from near and far to testify. There were a great number of witnesses, most of whom were persons familiar with the differences in the education and training of a podiatrist and orthopedic surgeon. Some of the orthopedic surgeons on the medical staff attended the meetings and in a few instances testified, but in most instances responded to questions by the attorneys for the podiatrists. As was pointed out at oral arguments by a Judge of the Fourth Circuit, there must be

something wrong when an attorney for a podiatrist asks an orthopedic surgeon a question, the orthopedic surgeon answers the question, and the orthopedic surgeon is then named by that attorney as a defendant in a lawsuit as his reward for having answered the question. That is the case with respect to several of the orthopedic surgeons named as defendants in this lawsuit. In any event, the overwhelming majority of the speakers at the hearings were persons who do not do foot surgery or compete with the applicants in any way, but were opposed to changing the Bylaws on quality of care grounds.

The Bylaws Committee recommended against changing the Bylaws. The Committee stated that the "primary basis" for its recommendation was that FMH has "several orthopedic surgeons on its staff, all of the functions performed by a podiatrist may be performed by an

orthopedic surgeon, and podiatrists do not receive a medical education or training equivalent to that received by orthopaedic surgeons." (JA at 103, et seq.) In short, orthopedic surgeons are trained to treat the whole person. The Executive Committee (only one of fourteen members was an orthopedic surgeon) unanimously adopted the Bylaws Committee's recommendation, as did the Board of Trustees (none of whom compete with podiatrists--in fact, only three of eighteen are physicians) at its October 14, 1980, meeting. The Board of Trustees reaffirmed its decision after further consideration by the Joint Conference Committee (no persons doing foot surgery were on this Committee).

Of the thirty-five persons who voted not to change the Hospital Bylaws on quality of care grounds, and voted to deny the surgical privileges requested, only one was a physician doing foot

surgery. The majority were lay persons.

Petitioners reapplied for staff privileges in September, 1981, after enactment of N.C.G.S. 131-126.11A. The evidence of petitioners' education and training was unchanged, and the qualifications for staff privileges had not been altered. The Credentials and Executive Committees again recommended denial of petitioners' applications for the reasons set out in the recommendation of the Bylaws Committee as follows: permitting podiatrists admitting and surgical privileges would be "inconsistent" with the Bylaws mandate that patients receive the "best possible care," and more specifically that "orthopedic surgeons as a group can better serve the needs of the whole patient by diagnosing and treating physical and emotional causes which manifest themselves in terms of foot disorders," as well as the fact that "podiatrists do not receive internship

and residency training equivalent to that of an orthopedic surgeon." (JA at 103, et seq.) Despite the Credentials and Executive Committees' recommendations of denial, additional hearings were held by an Ad Hoc Committee[4/] at which petitioners and others were again permitted to make presentations as to their education, training and qualifications. Once more the conclusion was reached that the Bylaws should remain unchanged and petitioners' applications should be denied in the interest of assuring the highest quality medical care possible. After more hearings at which the petitioners' attorneys appeared on their behalf, the Board of Trustees approved the recommendations of the Credentials and Executive Committees at its meeting on February 9, 1982, on quality of care grounds. (JA at 103, et seq.)

[4/] No member performs foot surgery.

ERRONEOUS AND MISLEADING STATEMENTS IN PETITION

Before addressing the questions presented by petitioners, a few general observations concerning erroneous or misleading statements made by the petitioners would seem appropriate:

1. District Court Found No Evidence Of A Conspiracy.

On page 11 of the Petition it is stated ". . . the district court assumed there was proof of conspiracy, but found that the respondents 'had a duty to insure that the hospital provide quality patient care and that the actions by the Board and the Bylaws Committee were in response to this duty'". It is clearly erroneous to state that the district court assumed there was proof of conspiracy. Rather, the court stated: "The Court find that plaintiffs have failed to establish any evidence of a conspiracy on the part of the association with other defendants . . ." (Page 16a of

Pet.'s App.); and, "the Court has found that no conspiracy existed against plaintiffs to deny them staff privileges at Forsyth Memorial." (Page 17a of Pet.'s App.).

2. Limited Education And Training Of Petitioners.

On page 8 of the Petition, it is stated that "No attempt was made to deal with petitioners' individual qualifications . . .". This is also wrong. The Bylaws Committee, Credentials Committee, and Board of Trustees considered the petitioners' individual qualifications in great depth, probably greater than any individual application ever received by the Hospital. In fact, one physician (who does not do foot surgery) accepted the invitation of the applicants to go to the school where they studied podiatry to review the curriculum, faculty, facilities, etc. The individual qualifications, after being considered in the greatest detail, disclosed that these

petitioners did not have the education and training that is required of a physician or anyone else that wishes to do foot surgery at FMH.

The petitioners would also have the Court believe that the education and training of a podiatrist is equal to that of an orthopedic surgeon. This is erroneous. The Bylaws Committee fully explored this contention during its many hours of hearings (with a detailed study of the curriculum of the Schools of Podiatry, and the post-graduate training of podiatrists, being made). The Committee properly determined that the podiatrist's training is woefully lacking with respect to physical and mental problems which manifest themselves in terms of foot disorders, and the proper means of treating the mental and physical problem as well as the foot problem.[5/]

5/One must ask why the Committee would go to such great lengths to get evidence as to the education and training of both groups if the Committee had already conspired, as the petitioners

The Bylaws Committee, Credentials Committee, Executive Committee, Joint Conference Committee, and the Board of Trustees shared this view.[6] So, too, do the Courts.[7]

Footnote continued

contend, to deny privileges.

[6] A transcript of the testimony before the Bylaws Committee was made avaliable to the Executive Committee and Board of Trustees so that they could review the testimony and exhibits comparing the education and training of podiatrists and orthopedic surgeons.

[7] The North Carolina Court, for example, put it this way:

> [T]he majority view is that a podiatrist must exercise that degree of ordinary skill and care which is commonly exercised by other podiatrists in the same locality under similar circumstances. He is not bound to possess and exercise the degree of care and skill required of an ordinary physician or surgeon. . . Our review of the appliable statutes and the record indicates that the practice of podiatry is a narrowly restricted one. This allied health profession is not at all comparable with the practice of medicine and surgery. The educational requirements for a podiatrist are less demanding than those for physicians and surgeons. See G.S. 90-202.5. . . . Podiatry is obviously an "allied occupation" (to medicine) in the contemplation of our state law . . . . (citations

The differences between podiatrists and "full practice" physicians was also central in a leading case concerning alleged substantive constitutional rights deprivations through denial of staff privileges, Shaw v. Hospital Authority of Cobb County, 507 F.2d 625 (5th Cir. 1976)("Shaw I") and 614 F.2d 946 (5th Cir. 1980)("Shaw II") cert. denied, 449 U.S. 955, 66 L.E.2d 220, 101 S.Ct. 362 (1980). In Shaw I the podiatrists argued that denial of privileges to them while granting them to medical doctors was a denial of equal protection. The Court concluded that it was

> . . . unable to equate the various branches of the healing arts which would necessarily be included . . . the facts simply do not make out a case of persons similarly situated within the equal protection clause treatment requirement that all persons similarly circumstanced shall

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Footnote continued

omitted).

Whitehurst v. Boehm, 41 N.C.App. 670, 676-677, 255 S.E.2d 761, 765, 767 (1969)(emphasis supplied).

> be treated alike. [Citation omitted].

Id. at 623. The Shaw II Court determined that the hospital authority's decision not to amend the bylaws, after the court-ordered hearings, was justified by the discretion allowed to Trustees in appointing staff. The JCAH guideline provision that a hospital governing body "may grant clinical privileges to qualified, licensed podiatrists. . ." supported that decision, and the bylaws were reasonably related to the operation of the hospital (citing Sosa v. Board of Managers of Val Verde Memorial Hospital, 437 F.2d 173 (5th Cir. 1971)). The Board of Trustees of FMH reached exactly the same conclusion as did the Judges of the Fifth Circuit which upheld the denial of admitting and surgical privileges to podiatrists:

> . . . orthopedic surgeons as a group can better serve the needs of the "whole patient" by diagnosing and treating physical and

emotional causes which manifest themselves in terms of foot and leg disorders.

3. Hospital Responsible For Quality Of Staff.

At the time the Board of Trustees of FMH was considering the petitioners' applications for surgical privileges, the Trustees were well aware of court cases finding hospitals to be liable for negligent selection of persons permitted to treat patients. There are numerous cases so holding, perhaps the most famous of which is Darling v. Charleston Memorial Community Hospital, 33 Ill.2d 326, 211 N.E.2d 253 (1965). Many have stated something along these lines: "The Governing Board remains ultimately responsible for the efficient operation of the hospital and maintenance of high standards of professional care. Final authority to appoint or reject a physician rests with the Governing Board." Yarnell v. Sisters of St. Francis, 446

N.E.2d 35 (Ind.App. 1983).

North Carolina courts have indicated that a hospital may be held negligent for improperly granting privileges. Cox v. Hayworth, 54 N.C.App. 328, 238, S.E.2d 392 (1981); Rabon v. Hospital, 269 N.C. 1, 152 S.E.2d 485 (1967).

The most recent statement by the North Carolina Courts re the authority of hospital trustees to grant and deny privileges on quality of care grounds is from a case in which the Court upheld the denial of surgical privileges to a podiatrist at New Hanover Memorial, Cameron v. New Hanover Memorial Hospital, 58 N.C.App. 414, dis. review by S.Ct. denied, 307 N.C. 127 (1982), and quoted from the Fifth Circuit case of Sosa v. Board of Managers of Val Verde Memorial Hospital, 437 F.2d 173 (5th Cir. 1981) as follows:

> No court should substitute its evaulation of such matters for that of the Hospital Board. It

is the Board, not the court, which is charged with the responsibility of providing a competent staff of doctors. The Board has chosen to rely on the advice of its Medical Staff, and the court cannot surrogate for the Staff in executing this responsibility. Human lives are at stake, and the governing board must be given discretion in its selection so that it can have confidence in the competence and moral commitment of its staff. The evaluation of professional proficiency of doctors is best left to the specialized expertise of their peers, subject only to limited judicial surveillance. The court is charged with the narrow responsibility of assuring that the qualifications imposed by the Board are reasonably related to the operation of the hospital and fairly administered. In short so long as staff selections are administered with fairness, geared by a rationale compatible with hospital responsibility, and unencumbered with irrelevant considerations, a court should not interfere.

Training is one of those relevant professional qualifications "which may be constitutionally applied in determining the class of people who are eligible to practice medicine in a public hospital."

Shaw v. The Hospital Authority of Cobb County, 614 F.2d 946, 952 (5th Cir. 1980), cert. denied, 449 U.S. 955 (1981), quoting Foster v. Mobil County Hospital Board, 398 F.2d 227, 230 (5th Cir. 1968). The Accreditation Manual for Hospitals (1979 ed.), p. 84, prepared by the Joint Commission on the Accreditation of Hospitals, specifically suggests that specialty board certification or eligibility "is an excellent benchmark to serve as a basis for, privilege delineation . . . ."

4. Persons Denied Privileges Includes All Inadequately Trained Persons.

Throughout, the petitioners use the phrase "denied privileges as a class". This is inaccurate. In the first place, the Record shows that the education and training of petitioners was given detailed consideration. In the second place, petitioners were not denied privileges "as a class", but were denied privileges because they do not have the education, training and experience that is required of an orthopedic surgeon or of a general surgeon. As noted previously, even an orthopedic

surgeon, with no more residency training that that possessed by the petitioners in this case, would not be granted privileges to do foot surgery at FMH.

The truth of the matter is that the petitioners were denied privileges because they do not have the training and experience of a surgeon who is a medical doctor. Thus, the class that is excluded from privileges at FMH is not podiatrists but is everyone in the entire world who does not have the training and experience of a surgeon who is a medical doctor.

With respect to education, training and experience, the Record shows that the post-graduate training (internship and residency) of petitioners is virtually nill whereas all orthopedic surgeons are required to have a minimum of five years of such training before becoming Board Eligible as orthopedic surgeons.

Our research, and apparently that of

the petitioners, fails to disclose any case in which a Court has determined that the difference in the education and training of medical doctor surgeons and podiatrists does not justify denying surgical privileges to podiatrists (except where state law mandates such privileges, which is not the case in North Carolina)(See cases cited on pages 32-33).

5. North Carolina Law Does Not Mandate Hospital Privileges For Podiatrists.

On page 7 of the Petition, there is a reference to the 1981 legislation which is referred to as ". . . a new statute that required hospitals to base the grant or denial of privileges on the individual applicant's education, training, competence and experience." What the petitioners fail to point out is that the statute also provided that the hospital base its grant or denial of privileges on ". . . the reasonable objectives and

regulations of the hospital in which such privileges are sought." The statute also provides: "Nothing in this article shall be deemed to mandate hospitals to grant or deny to any parties privileges to practice in said hospitals."

6. Licensing And Accrediting Agencies Do Not Mandate Hospital Privileges For Podiatrists.

The petitioners would have the Court believe that FMH is "out-of-step" with the various licensing and accrediting agencies in its view that podiatrists do not have the qualifications necessary to provide quality care "to the whole patient". References are made to the JCAH, the AMA, and the North Carolina Hospital Association. It is true that the publications of these organizations provide that the Board of Trustees of a local hospital is permitted to approve or disapprove admitting and surgical privileges to podiatrists. (JA at 207) There are undoubtedly

small hospitals in rural areas where there are no qualified orthopedic surgeons or general surgeons to provide foot surgery, and the addition of a podiatrist to the staff of such hospitals would not constitute a substantial reduction in quality of care. But, where there is an adequate number of qualified surgeons, trained to treat the whole body and not just the foot without reference to the condition of the whole body, such privileges should not be allowed. This was the conclusion reached after considering many hours of testimony with respect to the qualifications of petitioners.

The fact that the accrediting and licensing agencies feel that the local boards of trustees should make the decision as to surgical privileges for podiatrists, and the effect of same on the quality of care, is appropriate.

The petitioners assert that the Credentials Committee found that the competence

of the plaintiffs was unquestioned. Actually, this is not true. What the Credentials Committee determined, as did the Bylaws Committee, the Executive Committee and the Board of Trustees, was that petitioners did not have the education, training and qualifications of an orthopedic surgeon, and thus should not be permitted to do foot surgery at FMH. (See full Report of Bylaws Committee, JA at 103-107).

7. NCOA Played No Role In The Decision Of The Board Of Trustees Of FMH To Deny Petitioners Staff Privileges.

Petitioners continue to argue a "role" of the North Carolina Orthopaedic Association ("NCOA") when there was none. Contrary to petitioners' assertions and speculation, which was rightfully rejected by the two lower federal courts, the NCOA played absolutely no "role" in the consideration or denial of petitioners' requests for surgical staff privileges at

FMH.

The NCOA is a small (approximately 200 members), voluntary, non-profit, educational association. The discipline of orthopedic surgery in North Carolina has a history of patient concern and continuing scientific achievement, and the NCOA's membership includes members of the faculties of Duke University School of Medicine. Bowman Gray School of Medicine (Wake Forest University), East Carolina Medical School, and the University of North Carolina School of Medicine, as well as leading practitioners from across the State. The Association is primarily an educational one which meets twice each year, once in the fall and once in the spring. Each meeting of the NCOA is devoted almost entirely to matters of continuing education through the delivery of educational papers and programs on medical topics of current interest to orthopedic surgeons. There

are also social functions in connection with each meeting and short (usually less than one hour) business sessions at each general meeting. The business meetings are conducted for necessary and routine business matters such as the election of officers, committee reports, planning for subsequent meetings and consideration of legislative matters of interest to the group. (JA at 305, et seq.)

In the context of considering legislation which had been introduced in the 1975 General Assembly of the State of North Carolina, the NCOA went on record as being against the practice of podiatry in a hospital setting. The purpose of the resolution was to pass on to the North Carolina General Assembly the NCOA's concern for patient welfare. Between 1975 and early 1984, the NCOA did not have any stated position on the issue of the hospital practice of podiatry.

However, in 1984 the NCOA passed the following resolution, which constitutes the only position taken on podiatry by the NCOA since 1975:

> The North Carolina Orthopaedic Association, Inc., in the continued interest of providing the patient with the best possible care, recommends that the hospital practice of podiatry be determined at a local hospital level, based upon appropriately reviewed and credentialed individual qualifications and in accordance with all applicable laws and regulations.

At the behest of petitioners, the staff of the Federal Trade Commission began an investigation into the activities of the NCOA, particularly with regard to its position on podiatry and their exclusion from the surgical staff at FMH. After three years of investigation and negotiations with the NCOA, on September 19, 1986, the FTC filed a Complaint and Consent Decree, pursuant to which the NCOA made no non-jurisdictional

admissions and denied any liability whatsoever. Pursuant to that Consent Decree, the NCOA has retained its right to publish any representation regarding the training, education, practice or other qualifications of podiatrists for which it has a reasonable basis. It is important to note that there is no allegation in the FTC's Complaint nor is there any admission in the Consent Decree that the NCOA had anything whatsoever to do with the denial of staff privileges to the petitioners by the Board of Trustees of FMH. In fact, nowhere in the Complaint or the Consent Decree is there any mention of FMH or any of the individual respondents in this case.

ARGUMENT

I. ACCESS BY THE PETITIONERS HEREIN TO FMH IS A LOCAL ISSUE WHICH HAS NO NATIONAL SIGNIFICANCE

Petitioners' argument that this case involves issues of national significance

should have no bearing on this Court's decision as to whether the writ should be issued, since such argument does not fall within the scope of Rule 17 of the Supreme Court Rules. Furthermore, the fact that the two petitioners in this case were denied staff privileges at FMH is a wholly local concern. A number of courts have recognized that the granting or denying of staff privileges on quality of care grounds is a decision for the board of trustees of the hospital in question and not one where courts should substitute their evaluation of such matters for that of the hospital board. Sosa v. Board of Managers of Val Verde Memorial Hospital, supra.

The Cameron court reemphasized the position that staff privilege decisions are local matters for which the board of trustees of the hospital are ultimately responsible and that as long as the qualifications

imposed by the board are reasonably related to the operation of the hospital and fairly administered, those decisions should be left alone by the courts.

The claims made by the petitioners in the incident case are not novel. There have been several other cases brought around the country on antitrust grounds by podiatrists seeking to overturn the denial of staff privileges to them at particular hospitals. In every one of those cases, the courts have resoundingly upheld the decision of the board of trustees denying privileges. Feldman v. Jackson Memorial Hospital, 571 F.Supp. 1000 (S.D.Fla. 1983), aff'd. (mem) 752 F.2d 647 (11th Cir. 1985), cert. denied, 105 S.Ct. 3504 (1985); Cameron v. New Hanover Memorial Hospital, 58 N.C.App. 414, dis. review denied, 307 N.C. 127 (1982); Shaw v. Hospital Authority of Cobb County, 614 F.2d 946 (5th Cir. 1980), cert. denied, 449 U.S. 955 (1981);

Davidson v. Youngstown Hospital Association, 10 Ohio App.2d 246 (1969); Kaczanowski v. Medical Center Hospital of Vermont, 1985-2 Trade Cases, ¶66,752 (D.Vt. 1985). There are other cases in which the podiatrists have prevailed, but all of those cases involve state statutes which mandate that podiatrists be given staff privileges, which is not the case under the North Carolina statute.

The non-significance of the instant case and of podiatrists' access to staff privileges at hospitals is highlighted by the fact that this Court has on two previous occasions refused to review Circuit Court of Appeals decisions affirming the denial of staff privileges to podiatrists. Shaw v. The Hospital Authority of Cobb County, 614 F.2d 946 (5th Cir. 1980), cert. denied 449 U.S. 955 (1981); Feldman v. Jackson Memorial Hospital, 571 F.Supp.

1000 (S.D.Fla. 1983), aff'd. (mem) 752 F.2d 647 (11th Cir. 1985), cert. denied, 105 S.Ct. 3504 (1985). Thus, only a year ago this court refused to issue a writ of certiorari in Feldman which involved claims similar to the ones made herein involving alleged violations of Section 1 and Section 2 of the Sherman Act.

In short, there is no compelling reason why this Court should now take a podiatry case involving issues of purely local concern.

II. FTC ENFORCEMENT POLICY HAS NO BEARING ON THIS PETITION

Petitioners next contend that this Court should exercise its discretion in granting the Petition for Certiorari because the Fourth Circuit Court of Appeals' decision allegedly conflicts with the enforcement policy of the FTC in hospital access cases (Petition at 21).

Assuming arguendo that petitioners'

assertion is correct, which respondents deny, there are at least three reasons why it is insufficient for the Court's positive exercise of its discretion in this case.

First of all, FTC enforcement policy has nothing whatsoever to do with any issue in this case. Supreme Court Rule 17 alone would appear on its face to preclude the Court's consideration of FTC enforcement policy. There is nothing in Rule 17 which even remotely indicates this Court might give consideration to an alleged conflict between the Fourth Circuit opinion and FTC enforcement policy.

Secondly, the FTC is obviously not a party to this action. As petitioners are quick to observe, the FTC has investigated the North Carolina Orthopaedic Association regarding its overall attitude toward podiatrists and podiatry. Furthermore, the FTC was obviously satisfied with the

resulting Consent Decree, only a portion of which is reproduced in the Appendix to the Petition at 134a. What petitioners conspicuously omit from their reference to the Consent Decree are the facts that the Consent Decree is for settlement purposes only and does not constitute any admission by NCOA that it has violated the FTC Act; the fact that NCOA is a nonprofit corporation; and, the remainder of paragraph II of the Order which states

> PROVIDED that nothing in subpart II(B) shall prohibit respondent from making or publishing a representation for which respondent possesses a reasonable basis regarding the training, education, practice, or other qualifications of podiatrists or any individual podiatrists.
>
> PROVIDED FURTHER that nothing in this order shall prohibit respondent from exercising rights guaranteed by the First Amendment to the United States Constitution to petition any federal, state, or local government, executive agency, or legislative body concerning legislation, rules or procedures, or to participate in any federal, state, or local administrative or judicial proceeding.

Moreover, it is important to note in this context that the FTC obtained and thoroughly reviewed all of the records of FMH regarding its policies and procedures relating to podiatry and podiatrists, following which the FTC made no claim or allegation whatsoever regarding either FMH or its medical staff with regard to not granting surgical staff privileges to petitioners or otherwise. Consequently, it is patently ridiculous for petitioners to contend, as they do here, that the Fourth Circuit opinion conflicts with FTC enforcement policy when the FTC has investigated the very transaction of which petitioners complain without instituting any enforcement action whatsoever against FMH, its trustees or its medical staff.

Finally, it is important to note that the opinion and decision below were rendered in the context of this private treble damage action, which was brought under

sections 1 and 2 of the Sherman Act, 15 U.S.C. §§1 and 2, and State law. There is nothing in the petitioners' amended complaint, nor in either decision by the lower federal courts, which relates to FTC enforcement or enforcement policy. Indeed, the FTC Act does not provide for private claims for relief, and the courts which have considered the question have uniformly held that private rights of action may not be implied under the FTC Act. See, e.g., Holloway v. Bristol-Myers Corp., 485 F.2d 986 (D.C. Cir. 1973); Alfred Dunhill, Ltd. v. Interstate Cigar Corp., 499 F.2d 232 (2d Cir. 1974); Carolon v. Coca-Cola Co., 483 F.2d 279 (9th Cir. 1973).

III. THE FOURTH CIRCUIT'S DECISION IN THIS CASE DOES NOT CONFLICT WITH OTHER CIRCUIT DECISIONS REGARDING HOSPITAL ACCESS

The decision below of the Fourth Circuit Court of Appeals represents a sound and consistent application of well-established

rules of federal antitrust law to the particular facts of this case. The Fourth Circuit affirmed the federal district court's holding that the petitioners had presented insufficient evidence to support an antitrust claim against any of the defendants. This result is identical to the numerous federal district and circuit court opinions which have considered the responsibility of hospitals and its appointed committees to provide quality patient care through the credentialing process. Robinson v. Magovern, 521 F. Supp. 842 (W.D.Pa. 1981), aff'd, 688 F.2d 824 (3rd Cir. 1982); Smith v. Northern Michigan Hospital, 703 F.2d 942 (6th Cir. 1983); Pontius v. Children's Hospital, 552 F.Supp. 1352 (W.D.Pa. 1982); Feldman v. Jackson Memorial Hospital, supra; Vuciecebic v. MacNeal Memorial Hospital, 1983-2 Trade Cases (CCH) ¶65,711 (N.D. Ill. 1983); McElhinney v. Medical Protective

Co., 549 F.Supp. 121 (E.D.Ky. 1982); Kaczanowski v. Medical Center of Vermont, supra; cf., Cameron v. New Hanover Memorial Hospital, supra.

The decision of the district and circuit courts in this case are neither controlled by nor conflict with the Third Circuit Court of Appeals' decision in Weiss v. York Hospital, 745 F.2d 786 (3rd Cir. 1984), cert. denied, 53 U.S. L.W. 3669, 84 L.Ed.2d 836, 105 S.Ct. 1777 (1985), for the following reasons. First, unlike Weiss, the medical staff of FMH is not a defendant in this litigation. The petitioners did not allege that a "conspiracy" existed between and among the members of the medical staff to engage in any unlawful conduct.[8/]

[8/] The allegations in the complaint, paragraphs 37-42 (pages 30a and 31a of Pet. App.) are that the ". . . the defendants combined and conspired . . .", not that the medical staff combined and conspired.

With respect to the individual physicians named as defendants in the present case, the district and circuit courts, after thoroughly analyzing the participation of each physician, concluded that the plaintiffs proffered no evidence of conspiracy, and thus there was no illegal group boycott in violation of the Sherman Act.[9/]

[9/] The overwhelming majority of courts have held that medical professionals, like the orthopedic surgeon defendants in the present case, who serve on committees and who provide recommendations and advice, are not liable for such participation in corporate and agency decisions. These decisions have fallen into three general categories. First, most courts have reached this conclusion upon reasoning that to do otherwise would "chill" the expression of professional and expert opinion which is necessary for the proper care of patients. E.g., Smith v. Northern Michigan Hospital, supra; Stone v. William Beaumont Hospital, 1983-2 Trade Cases (CCH) ¶65,681 (E.D.Mich. 1983); Pontius v. Children's Hospital, supra; Robinson v. Magovern, supra. Second, courts have reached the same conclusion applying the doctrine that employees and agents of the same corporation cannot be held liable for conspiring with each other to produce corporate action. Copperweld Corp. v. Independent Tube Corp., 476 U.S. 752, 81 L.Ed.2d 628, 104 S.Ct. 2731 (1984); Robinson v. Magovern, supra;

Second, in Weiss, the court found that York Hospital was both controlled and dominated by M.D.s. In this case, however, petitioners alleged in their amended complaint (¶5) that the governing body of the hospital was the Board of Trustees, some 16 in number, 12 of whom were lay members. The Record shows that the final authority and control of staff privileges at FMH

Footnote continued

Pontius v. Children's Hospital, supra; Stone v. William Beaumont Hospital, supra; Sokol v. University Hospital, 402 F.Supp. 1029 (D.Mass. 1975). See generally, Harvey v. Fearless Farris Wholesale, Inc., 589 F.2d 451 (9th Cir. 1979). Third, the United States Supreme Court reached a similar conclusion in holding that members of committees which considered and made recommendations to a state bar examining committee were not subject to liability for their participation under the state action exemption to the Sherman Act, in Hoover v. Ronwin, 466 U.S. 558, 104 S.Ct. 1989, 80 L.Ed.2d 590 (1984), applying Parker v. Brown, 317 U.S. 341 (1943). In Hoover, the Court noted that allowing a Sherman Act plaintiff to look behind the actions of a body advising a bar committee would "emasculate" the doctrine that such an agency or committee must determine the fitness of applicants for a law license. E.g., Sausalito Pharmacy, Inc. v. Blue Shield of Cal., 677 F.2d 47 (9th Cir. 1982).

was vested in the Board of Trustees by statute, charter and bylaws.

Third, in Weiss, it was admitted that the osteopaths were as qualified as M.D.s. The findings here were to the contrary.

IV. THE LOWER COURTS CORRECTLY APPLIED PRIOR DECISIONS OF THIS COURT IN GRANTING AND AFFIRMING SUMMARY JUDGMENT

Petitioners contend that the Court of Appeals applied an incorrect standard for summary judgment because it relied on this Court's standard set forth in Monsanto Co. v. Spray-Rite Service Corp., 465 U.S. 752, 768 (1984). Petitioners contend that because Monsanto was a "dealer termination" case that the test it sets forth is somehow inapplicable in any other antitrust context.[10/]

[10/] The test, when set forth in its entirety requires that:

> The correct standard is that there must be evidence that tends to exclude the possibility of independent action by manufacturer and distributor. That is,

However, petitioners overlook the fact that Monsanto is not just a "dealer termination" case, but is also a "group boycott" case alleged under Section 1 of the Sherman Act, which is precisely the claim made by petitioners in this case.

Moreover, in this Court's recent decision in Matsushita Electric Industrial Co., Ltd. v. Zenith Radio Corporation, 475 U.S. _____, 106 S.Ct. _____, 89 L.Ed.2d 538 (1986), this Court made it clear that its standard for antitrust conspiracy set forth in Monsanto applies in non-dealer termination cases brought under Section 1 of the Sherman Act. In reversing the Third Circuit Court of Appeals, which earlier had reversed the district court's summary

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Footnote continued

> there must be direct or circumstantial evidence that reasonably tends to prove that the manufacturer and others had a conscious commitment to a common scheme designed to achieve an unlawful objective.

judgment based upon an absence of significant probative evidence of antitrust conspiracy, this Court stated as follows:

> Thus, in Monsanto Co. v. Spray-Rite Service Corp. (citation omitted), we held that conduct as consistent with permissible competition as with illegal conspiracy does not, standing alone, support an inference of antitrust conspiracy. (Citations omitted). To survive a motion for summary judgment or for a directed verdict, a plaintiff seeking damages for a violation of §1 must present evidence "that tends to exclude the possibility" that the alleged conspirators acted independently. (Citation omitted). 89 L.Ed.2d at 553. (Emphasis added)

V. THE DISTRICT COURT AND THE COURT OF APPEALS PROPERLY APPLIED THE MONSANTO STANDARD

Both the district court and the Court of Appeals had ample evidence before them in the form of depositions, minutes of various meetings, attended by the podiatrists and their attorneys, and affidavits tendered by various defendants to discern whether a conspiracy violating Section 1 of the Sherman Act could be

inferred from the evidence presented. The Court of Appeals correctly points out that petitioners have offered no direct evidence of a conspiracy, but fully recognizes that under the Monsanto test, they may rely on inferences of a conspiracy which can be drawn from circumstantial evidence.

Neither court below has departed in any way from "accepted standards for summary judgment". Rule 56 of the Federal Rules of Civil Procedure most certainly applies in antitrust cases, and whether the Court of Appeals had applied the standard as set forth in Monsanto or had merely applied the language of the Rule, there simply was no evidence presented by petitioners at any stage of this proceeding to raise any issues of material fact regarding their conspiracy claim. The Monsanto test actually gives petitioners the benefit of the doubt by allowing them to survive a

motion for summary judgment if they can present sufficient circumstantial evidence from which to draw an inference of a conspiracy. This is a lenient test, which petitioners have obviously failed.

SUMMARY

In summary, respondents respectfully submit that the considerations specified in Rule 17 of the Supreme Court Rules do not exist in this case, and thus the Petition should be denied.

Respectfully submitted this 22nd day of October, 1986.

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CLERK

No. 86-471

IN THE

Supreme Court of the United States

OCTOBER TERM, 1986

CARLOS T. COOPER, JR., D.P.M. and
E. JOSEPH DANIELS, D.P.M.,
Petitioners,

v.

FORSYTH COUNTY HOSPITAL AUTHORITY, INC., *et al.*,
Respondents.

PETITIONERS BRIEF IN REPLY TO BRIEF FOR THE RESPONDENTS IN OPPOSITION TO CERTIORARI

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PETITIONERS BRIEF IN REPLY TO BRIEF FOR THE RESPONDENTS IN OPPOSITION TO CERTIORARI

Petitioners submit this brief in reply to the respondents' brief in opposition to *certiorari* ("Opp. Cert."). Curiously, while defending summary judgment granted to them, respondents raise a variety of factual disputes.[1] They fail, however, to minimize the national importance of the hospital access antitrust issue presented here or to rebut the significant conflict between the decision below and that of the Third Circuit in *Weiss v. York Hospital*, 745 F.2d 786 (3d Cir. 1984), *cert. denied*, 105 S. Ct. 1777 (1985).

To begin with, respondents do not dispute the economic impact of the exclusion at issue in this case. *See* Pet. at 5-6. Podiatrists and orthopedists compete in providing inpatient foot surgery. Forsyth Memorial is the only hospital available to petitioners in the relevant geographical market. By denying them co-admitting privileges, respondents have, over a five-year period, forced Drs. Cooper and Daniels to refer 388 of their foot surgery patients to staff physicians at the Hospital. Thus, Drs. Cooper and Daniels have lost the income associated with providing such treatment; and, equally important, their patients have lost the right to use the health care provider of their choice.

This restraint on competition and consumer choice strikes at the core of the values protected by the antitrust laws. As this Court has often reiterated, those laws "are as important to the preservation of economic freedom and our free-enterprise system as the Bill of Rights is to the protection of our fundamental personal freedoms." *United*

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[1] Indeed respondents devote the majority of their brief to arguing about alleged errors and misstatements of fact in the petition. Opp. Cert. at 12-30. Petitioners disagree with all of these contentions. Yet, most of them have little bearing on whether the Court should grant *certiorari*. To the extent they may relate to that issue, petitioners discuss them in the body of this reply brief.

States v. Topco Assocs., Inc., 405 U.S. 596, 610 (1972). Since the antitrust laws embody our national policy of free enterprise and provide national standards and remedies that are unavailable under state tort or hospital laws, they represent the best means to redress anticompetitive practices in the health care industry.

The claimed "woefully" inadequate training of podiatrists (Opp. Cert. at 13-18) does not shield respondents' exclusionary conduct from antitrust scrutiny. Not only does this claim raise genuine fact issues, but it is flatly contradicted by the unanimous and unequivocal recommendations of authoritative medical and governmental bodies that podiatrists should be granted co-admitting privileges based on their individual qualifications. Pet. at 3-4. For example, the AMA formally resolved "that podiatrists as a professional group should not be denied practice privileges in hospitals" (App. E at 58a); and the North Carolina Governmental Evaluation Commission reported in 1980 that:

> The disadvantages of the blanket exclusion of podiatrists from consideration for hospital privileges are apparent. . . . [K]eeping podiatrists out of hospitals *prevents them from performing surgical procedures that they are already licensed to perform, thereby imposing an unnecessary restriction on the public's foot care options.* Patients needing foot surgery administered in a hospital setting would be forced to seek a physician for the operation. *If a podiatrist can perform surgery in his office, it is difficult to understand why he shouldn't be permitted to do the same thing in a hospital.*

App. X at 156a (emphasis added). Both the Joint Commission on Accreditation of Hospitals and the North Carolina Hospital Association recommended that podiatrists should be considered for co-admitting privileges with a

staff physician, and that, in this "dual responsibility," the M.D. would be responsible for the "general medical care" of the patient. App. F at 59a; App. G at 61a.

Consistent with these recommendations, Drs. Cooper and Daniels sought only the privilege to co-admit their surgical patients with a staff M.D. to be responsible for the medical care of the patient. Since petitioners seek only co-admission privileges, respondents' asserted patient care justification for the categorical exclusion of podiatrists is highly implausible. How can concern for treatment of "the whole person" (Opp. Cert. at 9) justify the class exclusion of podistrists when they seek only JCAH-approved co-admitting privileges?

In this setting, there can be no legitimate doubt that the decision in this case upholding summary judgment for respondents raises important national issues and creates a clear conflict among the circuits.

1. There Is a Direct Conflict Between the Decision Below and *Weiss v. York Hospital*; the Cases Are Not Distinguishable

In *Weiss*, the Third Circuit held that the York Hospital medical staff was "a combination of individual doctors and therefore . . . any action taken by the medical staff satisfies the 'contract, combination or conspiracy' requirement of Section 1." 745 F.2d at 814. This holding, as we have shown (Pet. at 17-25), provides a sound basis for applying the Sherman Act in the large and growing number of hospital access cases.[2] It is well-grounded in antitrust prin-

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[2] As pointed out in the Petition, between January 1980 and September 21, 1986, the federal courts had resolved 115 such cases compared to only 37 in the prior six year period. Pet. at 17, n.10. A subsequent LEXIS search on October 29, 1986 revealed that between September 30 and October 16, 1986, three additional opinions were filed in hospital privileges cases.

ciples;[3] it comports with the realities of the credentialing process at York, Forsyth Memorial and most other hospitals;[4] it contemplates a factual determination of whether the concerted denial of privileges had a valid health care justification;[5] and, finally, it is fully consistent with the Federal Trade Commission's enforcement policy in hospital access cases.[6]

We have shown that this case and *Weiss* are not distinguishable and that there is a direct and important conflict between the two cases. Pet. at 17-21. Respondents have attempted to minimize that conflict with three inapposite or false arguments: (1) "unlike *Weiss*, the medical staff of FMH is not a defendant in this litigation" (Opp. Cert. at 40); (2) unlike *Weiss*, the Forsyth Memorial Board has "the final authority and control of staff privileges . . ." (Opp. Cert. at 42); and (3) unlike the osteopaths in *Weiss*, podiatrists are not as qualified as M.D.'s (Opp. Cert. at 43).

The first argument is inapposite. The antitrust laws look to substance, not to form (*Copperweld Corp. v. Independence Tube Corp.*, 467 U.S. 752, 763 (1984)) and allow a plaintiff to sue any one or more of the alleged co-conspirators. *See, e.g., Wilson P. Abraham Constr. Corp. v.*

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[3] *See Weiss*, 745 F.2d at 815-16; and Federal Trade Commission, *Enforcement Policy with Respect to Physician Agreements to Control Medical Prepayment Plans* (1981) at 6-7 ("Physician Control Statement").

[4] *See* Pet. at 14-17, 19-21; and *Weiss*, 745 F.2d at 796-99.

[5] *See Weiss*, 745 F.2d at 820-22; and Winslow, *Antitrust and Alternative Health Care Systems*, presented to the Antitrust and Health Care Sections, Minnesota State Bar Association at 15-16 (May 25, 1983).

[6] *See* Pet. at 21-25. While respondents contend that "FTC enforcement policy has nothing whatsoever to do with any issue in this case" (Opp. Cert. at 35) petitioners have shown that the lower courts' summary dismissal of the complaint is contrary to the FTC's enforcement approach in hospital access cases. Pet. at 21-25.

Texas Indus., Inc., 604 F.2d 897, 904 n.15 (5th Cir. 1979), *aff'd sub nom. Texas Indus., Inc. v. Radcliffe Materials, Inc.*, 451 U.S. 630 (1981). In the case of an unincorporated association, such as the Forsyth Memorial staff, "it is permissible to sue but one of several alleged co-conspirators." *Hennessey v. NCAA*, 564 F.2d 1136, 1147 (5th Cr. 1977). Here, the complaint named as defendants seven orthopedist-staff members, three allopathic physician staff members and the members of the Board of Trustees, alleging that they "combined and conspired to restrain trade and commerce by denying the plaintiffs hospital privileges. . . ." App. C at 19a-21a, 30a. These allegations are plainly sufficient to state a claim of conspiracy among the staff.

Respondents' second argument is false. At York Hospital, no less than at Forsyth Memorial, the hospital's governing body nominally has the final authority over staff privileges.[7] In reality, however, at both hospitals the medical staffs' "recommendations" were dispositive. *See* Pet. at 19-21. Under the Forsyth Memorial Bylaws, the medical staff physicians initially determine privilege issues, subject only to the Board's review as an "appellate body" (Pet. at 6); and the Board cannot overturn a privileges recommendation without holding a conference with staff for reconsideration (App. D, Art. V, § 2(i) at 42a-43a). Moreover, the political power of the physicians (*see* Pet. at 16-17) was repeatedly acknowledged by the Forsyth Memorial Board members. App. L at 84a-85a, 88a-90a, 95a-97a.[8]

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[7] As the Court of Appeals noted in *Weiss*, the hospital's "Board of Directors . . . held a special meeting at which presentations were made by counsel for Weiss and special counsel for the Hospital. On March 13, 1979, the Board voted to deny Weiss staff privileges." 745 F.2d at 799.

[8] For example, Mr. Armfield complained that the unanimous opposition to podiatry by "the whole staff plus the orthopaedists . . ." had placed him and other lay members "between a rock and a hard place. . . ." App. L at 84a. Similarly, Board member Dr. Shaffner argued, "If this board does not support the recommendations of the medical staff and thus directs

Respondents' third argument is equally meritless. Since this case was decided on summary judgment, there were no "findings" as to the relative competence of podiatrists and M.D.'s. *See* Opp. Cert. at 43. In fact, Drs. Cooper and Daniels unquestionably have "the highest qualifications" individually, as Board member Thomas stated (App. L at 96a); and the qualifications of podiatrists as a class for co-admitting privileges has been definitively resolved by the AMA, JCAH and others.[9]

Respondents' remaining contention—that there can be no concerted action here since "[o]f the thirty-five persons who voted not to change the Hospital Bylaws . . . only one was a physician doing foot surgery" (Opp. Cert. at 9-10)—is also unavailing. All orthopedists on staff compete with petitioners and all agreed to written Bylaws categorically excluding non-physicians from staff. (App. D, Art. III, § 1 at 37a). Staff orthopedists vowed to "fight individually and collectively to keep podiatrists off the staff" and voted "that none will supervise podiatrists in [the] hospital." App. S at 125a. All seven of the defendant orthopedist staff members actively participated in the Hospital's proceedings and opposed petitioners' applications

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the staff to amend the by-laws to accommodate podiatrists, then we will have a serious internal problem. . . . We would have said that we believe they have been incompetent or dishonest. . . . We would have lost their confidence and their cooperation and I'm sure we'll lose some members of the staff who will resign." App. L at 93a.

[9] Respondents' suggestion that the lower courts have recognized podiatry as an inferior practice to orthopedics (Opp. Cert. at 15-18) is false. The cases relied on by respondents do not support the proposition. *See, e.g.*, Whitehurst v. Boehm, 41 N.C. App. 670, 675, 255 S.E.2d 761, 766 (1979) (orthopedic surgeon unfamiliar with podiatry could not establish standard of care required of podiatrists; "While the law recognizes that there are different schools of medicine, it does not favor, or give exclusive recognition to, any particular school or system of medicine, as against the others.").

and any amendment of the Bylaws.[10] Finally, respondents' contention seriously misconstrues the governing law, since if a Sherman Act conspiracy required proof that the conspirators formally "voted" to commit the illegal act, then there would never be another Section 1 conviction.[11]

2. The Hospital Access Issue Presented Here Is Not One of "Wholly Local Concern"

Respondents make two erroneous contentions in opposition to petitioners' argument that the issue presented here is nationally significant. First, they contend that this Court may not consider the national significance of this case "since such argument does not fall within the scope of Rule 17 of the Supreme Court Rules." Opp. Cert. at 30-31. This claim, of course, ignores both Rule 17 itself ("special and important reasons"; "important question of federal law") and this Court's established practice. *See,*

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[10] *See, e.g.*, Defendants Underdal (App. J at 74a-76a); Pollock (App. J at 69a-72a); Tomberlin (6/6/82 Tr. Bd. Mtg. at 58-72; 7/9/82 Tr. Bd. Mtg. at 9-45, 47-59); Hays (6/6/82 Tr. Bd. Mtg. at 73-90); Rose (6/6/82 Tr. Bd. Mtg. at 90-92, 109; 6/9/82 Tr. Bd. Mtg. at 116-42); Bittinger (6/6/82 Tr. Bd. Mtg. at 101-102); Jennings (6/6/82 Tr. Bd. Mtg. at 115-21, 127-29; 7/9/82 Tr. Bd. Mtg. at 142-56).

[11] Respondents' reliance on Shaw v. Hosp. Auth., 614 F.2d 946 (5th Cir.), *cert. denied*, 449 U.S. 955 (1980), for their contention that the courts of appeal have routinely affirmed denial of hospital access to podiatrists under the antitrust laws, and that this Court has denied review, is misplaced. Opp. Cert. at 32-33. *Shaw* did not involve any antitrust claim. Similarly, although Feldman v. Jackson Memorial Hosp., 571 F. Supp. 1000 (S.D. Fla. 1983), *aff'd mem.*, 752 F.2d 647 (11th Cir.), *cert. denied*, 105 S. Ct. 3504 (1985), is an antitrust action, the plaintiff had alleged a conspiracy among 17 hospitals and various orthopedists. Thus, it is quite different from a case such as this one which challenges the denial of privileges by concerted action within one hospital. Many of respondents' other cited cases were state court actions that did not involve the federal antitrust questions presented by this case. *See, e.g.*, Cameron v. New Hanover Memorial Hosp., 58 N.C. App. 414, *dis. review denied*, 307 N.C. 127 (1982); Davidson v. Youngstown Hosp. Ass'n, 10 Ohio App. 2d 246 (1969).

e.g., Rice v. Sioux City Cemetery, 349 U.S. 70, 79 (1955) ("special and important reasons").

Second, and equally misguided, is respondents' unsubstantiated assertion that hospital access by non-physician health care providers "is a local issue which has no national significance." Opp. Cert. at 30. Respondents dispute neither the reasoning nor authorities relied on by petitioners in demonstrating national significance. *Compare* Pet. at 13-17, *with* Opp. Cert. at 30-34. Further, in attempting to rebut petitioners' argument that they were the victims of a class exclusion, respondents' own contentions clearly reveal that this is a case of national significance.

Respondents emphatically claim that "The class that is excluded from privileges at FMH is not podiatrists but is everyone in the entire world who does not have the training and experience of a surgeon who is a medical doctor." Opp. Cert. at 22. Thus, according to their own explanation, respondents seek to exclude "everyone in the entire world" who is not an M.D. *That, petitioners submit, is exactly the point.* In addition to podiatrists, respondents' class exclusion would embrace osteopaths, clinical psychologists, nurse practitioners and nurse midwives. Such blanket exclusion of non-M.D. providers, as we have shown (Pet. at 14-17), seriously threatens consumer welfare.

Respondents' resolute determination to exclude *all* non-physicians under *all* circumstances, regardless of what the AMA, JCAH and others may say, except possibly in "small hospitals in rural areas where there are no qualified orthopedic surgeons or general surgeons . . ." (Opp. Cert. at 25), reveals two additional reasons why *certiorari* should be granted here:

First, it shows why the antitrust laws are needed in the hospital access setting. Neither state laws dealing with hospital access, such as that adopted in North Carolina in 1981, nor the strong recommendations of the standard-

setting agencies (*e.g.*, AMA, JCAH and NCHA) have been effective to breathe competition into the insular world of the physician-dominated hospital staff. *See* Pet. at 15-17.

Second, since this case involves the grant of summary judgment to respondents, it in effect creates the very antitrust exemption for M.D.'s which both Congress[12] and this Court[13] have recently rejected. If there can be no genuine issue of fact as to concerted action even where (a) the staff Bylaws establish such class exclusion,[14] (b) the staff effectively controls the process,[15] (c) the staff orthopedists directly compete with podiatrists,[16] (d) the staff orthopedists agreed to "fight individually and collectively to keep them off the staff"[17] and to boycott their supervision if they won access,[18] and (e) the asserted patient care excuse is highly implausible,[19] then all hospital access decisions effectively become exempt from antitrust scrutiny. This practical result also supports the exercise of this Court's discretionary review.

CONCLUSION

This Court should review this case because the legal questions it presents are critical to opening compet-

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[12] *Compare* 153 CONG. REC. H10,448, S15,706 (daily ed. Dec. 20, 1982), *with* 138 CONG. REC. H8755 (daily ed. Dec. 1, 1982) *and* S. 2499, 97th Cong., 2d Sess. (1982).

[13] Arizona v. Maricopa County Medical Soc'y, 457 U.S. 332, 349 (1982).

[14] The Staff adopted written Bylaws which all parties agree expressly deny privileges to all but physicians and dentists. Pet. at 7; Opp. Cert. at 4-5.

[15] *See* Pet. at 6; and discussion *supra* at 5.

[16] Pet. at 5; App. I at 65a-68a.

[17] App. S at 125a; App. Q at 119a.

[18] App. S at 125a.

[19] Petitioners were qualified for access (Pet. at 3) and applied for the privilege to co-admit with an M.D. (Pet. at 2).

itive access to the insular health care industry whose costs now consume over 10 percent of our gross national product.[20]

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[20] In 1985 health care costs reached $425 billion. U.S. Dept. of Health & Human Services, HHS News (Press Release) at 1 (July 29, 1986) (citing HEALTH CARE FINANCING REVIEW, *National Health Care Expenditures* (Fall 1986). *See* Pet. at 14.